

**Barriers and facilitators of retention to a psychosocial intervention  
among adolescents with common mental disorders in Harare:**

**A qualitative study.**

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## **Abstract**

**Dissertation title:** Barriers and facilitators of retention to a psychosocial intervention among adolescents with common mental disorders in Harare: A Qualitative Study.

**Background:** Common mental disorders, which account for a major proportion of disease burden globally, can have an onset in childhood and adolescence. The Friendship Bench is a psychosocial intervention aimed at reducing and treating common mental disorders and is provided at 42 city health department clinics in Harare, Zimbabwe. Yet research and anecdotal evidence suggests that adolescents do not remain engaged in this intervention. Reasons for lack of engagement often include demographic, psychosocial, logistical and cultural factors. Understanding the barriers and facilitators to retention amongst adolescents would help to improve retention and mental health outcomes among this vulnerable population. The aim of this study is to explore the barriers and facilitators that adolescents with common mental disorders experience in retention to the Friendship Bench.

**Methods:** A qualitative study was conducted among adolescents who were aged 15-17 years at the time of accessing the Friendship Bench service. Twelve adolescents who visited the Friendship Bench between June 2016 and December 2017 were recruited using purposive sampling. Theoretical saturation was not reached due to recruitment barriers. The adolescents were recruited from five primary care clinics which were selected based on ease of access to the researcher. Semi-structured interviews with open-ended questions were employed to explore the barriers and facilitators adolescents faced in accessing the service, guided by Andersen's Behavioural Model of Health services use. The interviews were conducted in a space convenient to the participant or at the participant's local clinic grounds, and they lasted approximately 30 minutes. The adolescents were interviewed by two qualitative researchers and given the option on whether to be interviewed in Shona or English. Data was analysed using thematic analysis with NVivo 12.

**Results:** Barriers to returning to the service included lack of privacy, school or work commitments, poor social support systems, and lack of a nearby clinic, resulting in having to travel far to access clinic services. Some participants who felt better saw no need to continue coming for sessions. Other emerging barriers found included lay health workers' (LHWs') attributes and forgetfulness. Important facilitators to retention included knowledge of what depression is, family support, experience with depressive symptoms, a nearby clinic, having other reasons to visit the clinic, and LHW attributes.

**Discussion:** Given the study's findings, it is recommended that mobile Friendship Benches and phone-based counselling applications be introduced, in addition to recruiting younger LHWs and male LHWs in order to improve retention. Provision should be made to locate Friendship Benches in more private or youth friendly spaces, to raise awareness on mental health issues in schools and communities and to involve parents and caregivers in the intervention development process. Further investigation into barriers and facilitators into psychosocial interventions is required, particularly with LHWs in order to get their perspective.

**Conclusion:** By identifying barriers and facilitators that adolescents experience, this study contributes towards improving access and retention of adolescents to the Friendship Bench, as well as other psychosocial interventions aimed at adolescents in Zimbabwe.

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# List of Abbreviations

**CMDs** – Common Mental Disorders

**DALYs** - Disability-Adjusted Life Years

**HIV** - Human Immunodeficiency Virus

**STIs** – Sexually Transmitted Infections

**LMICs** – Low- and Middle-Income Countries

**PST** – Problem Solving Therapy

**CKT** – Circle Kubatana Tose

**LHW** – Lay Health Worker

**SSQ-14** – Shona Symptom Questionnaire 14

**RCT** - Randomized Control Trial

# Chapter 1: Introduction

## 1.1 Introduction

Common mental disorders (CMDs), such as depression and anxiety, affect a large number of people worldwide. Global evidence indicates that over 300 million people suffer from depression, while 264 million people suffer from anxiety disorders (World Health Organization 2017). In Zimbabwe, country estimates in 2015 showed that 4% of the total population suffered from depression, and 2.8% suffered from anxiety (World Health Organization 2017). Approximately one-quarter of the global population consists of young people, 90% of whom reside in resource-poor settings like Zimbabwe (Blum and Boyden 2018). Among young people, depression and anxiety rates in 2015 were 5% and 3.3%, respectively, with higher rates among females than males for both depression and anxiety (World Health Organization, 2017).

Depression, in particular, can have significant implications on adolescents' behaviour, as well as on adolescents' mental health in adulthood. Depression is a risk factor for suicide among the general population, including adolescents, with suicide being the second leading cause of death amongst adolescents (Windfuhr, While et al. 2008, World Health Organization 2017). If left untreated, CMDs among adolescents also have several repercussions in adulthood as most mental disorders begin to develop early. For example, depression in adolescence can manifest as an anxiety disorder, substance-related disorder, or bipolar disorder in adulthood (Fergusson, Horwood et al. 2005). CMDs have also been found to result in poor adherence to anti-retroviral (ARV) medication (Nakimuli-Mpungu, Bass et al. 2012).

The majority of the burden of CMDs lies in resource-poor settings with only a minority of the population getting the care they need (Patel, 2011), which leads to the 'treatment gap'. Despite the burden of disease of mental disorders and the consequences of untreated CMDs, the public mental health sector in Zimbabwe remains hugely under-resourced. Indeed, the population of 13 million in Zimbabwe depends on just twelve psychiatrists (Chibanda, 2017). This is in addition to other factors such as inadequate budgetary allocation, poor remuneration and outdated policies which are poorly implemented (Kidia, Machando et al.

2017). These factors contribute to the treatment gap in the country. A task-sharing approach known as the Friendship Bench has been adopted in some parts of Zimbabwe. The Friendship Bench is a brief psychosocial intervention aimed at helping to reduce the burden of CMDs (Chibanda, Mesu et al. 2011). The intervention includes six, 30-45 minute individual sessions of problem-solving therapy (PST), as well as a support group component aimed at reducing symptoms of depression and anxiety (Chibanda, Mesu et al. 2011). A randomized control trial (RCT) conducted among primary care attending adults showed that the Friendship Bench intervention is effective in treating CMD (Chibanda, Bowers et al. 2015, Chibanda, Weiss et al. 2016).

Friendship Bench process data suggests that many of the clients referred to the Friendship Bench do not return for a second session, especially adolescents. This pattern has been observed globally - adolescents often do not access services or adhere to treatment or sessions in LMICs, even when effective mental health services are available (Wang, Aguilar-Gaxiola et al. 2007, Michael and Crowley 2002, Merikangas, He et al. 2011). An estimated 40–60% of young people in mental health treatment drop out before completing treatment, resulting in increased risk for ongoing clinical symptoms and functional impairment, lower satisfaction with treatment, and other poor outcomes (Miller, Southam-Gerow et al. 2008).

Several studies have been conducted to investigate barriers and facilitators to accessing mental health services generally. Stigma and discrimination were common barriers reported among several studies (Gulliver, Griffiths et al. 2010, Kozloff, Cheung et al. 2013, Brown, Rice et al. 2016, Fischer, McSweeney et al. 2016, McCann, Mugavin et al. 2016, McNair and Bush 2016). Age, gender, race, marital status and education level also had a bearing on mental health service use (Carson, Le Cook et al. 2010, Bruwer, Sorsdahl et al. 2011, Cummings 2014, Westin, Barksdale et al. 2014). Other common barriers include confidentiality, trust issues and poor mental health literacy (Hudson, Nyamathi et al. 2010, Gulliver, Griffiths et al. 2012, McCann, Mugavin et al. 2016). Some of the most instrumental factors in facilitating help-seeking behaviour include realizing the need to seek help, pleasant past experiences in seeking help, the ability to create rapport with the service provider and encouragement or

social support received (Gulliver, Griffiths et al. 2012, Kozloff, Cheung et al. 2013, Fischer, McSweeney et al. 2016).

Although several studies have been conducted to investigate barriers and facilitators using both quantitative and qualitative methodologies, both in high income and low-income settings, there is a paucity of evidence surrounding barriers and facilitators to retention to psychosocial interventions in Zimbabwe, particularly among adolescents. Given the lack of research in this area, this study used qualitative methods to explore and identify adolescents' perceptions of barriers and facilitators to retention to the Friendship Bench in Zimbabwe, in order to improve access and mental health outcomes of adolescents suffering from CMDs, as well as contribute towards reducing the burden of CMDs.

The study will provide valuable insight to assist community health workers within a primary care set-up, on how to engage with adolescents presenting with symptoms of CMDs. Andersen's Behavioural Model of Health Service Use (Andersen, 1995) will be used to guide the investigation into the perceived barriers and facilitators that adolescents encounter in retention to the Friendship Bench. This model has been successfully used in other low-income settings (Davidson, Andersen et al. 2004) among which include Guangxi in China, the Kersa District in Eastern Ethiopia and South Eastern Nigeria.

## 1.2 Aim

To explore the perceived barriers and facilitators that adolescents with common mental disorders (CMDs) experience in retention to a psychosocial Intervention.

## 1.3 Objectives

- To investigate the perceived barriers adolescents face in retention to a psychosocial intervention.
- To explore the perceived factors that facilitate retention to a psychosocial intervention.

#### 1.4 Dissertation Outline

Following the introduction, the second chapter will focus on a review of literature relevant to this study. Chapter three will provide the methods and procedures used in this research study. Study results or findings will be presented in the fourth chapter, and the fifth chapter will comprise a discussion that will involve a critical examination of study findings in relation to existing knowledge on the subject, as well as an overview of the lessons learnt from my work and implications for psychosocial interventions in Zimbabwe.

# Chapter 2: Literature Review

## 2.1 Introduction

This chapter provides the rationale for conducting the present study. The review will begin by reporting the global disease burden, the prevalence rates of common mental disorders (CMDs), and the consequences of untreated CMDs. This will be followed by an overview of mental health and the treatment gap in Zimbabwe, and the availability of mental health services at primary care level in Zimbabwe specifically, with special emphasis on the 'Friendship Bench' Intervention. An overview of the literature pertaining to the barriers and facilitators to mental health services that individuals with common mental disorders (CMDs) experience will then be provided. This is done in the context of Andersen's Behavioural Model of Health Service Use. Finally, the theoretical framework that will be used to investigate the perceived barriers and facilitators of retention in the present study will be described in detail.

## 2.2 Prevalence and Burden of Common Mental Disorders

Common mental disorders (CMDs), which include depression and anxiety disorders, account for a major proportion of disease burden (World Health Organization 2004), with over 300 million people suffering from depression and 264 million from anxiety worldwide (World Health Organization 2017). This represents 4.4% and 3.6% of the global population, respectively (World Health Organization 2017).

Prevalence rates for CMDs vary widely, however, in terms of gender, region and age groups. Indeed, both depression and anxiety are more common among females than males in the adult population (World Health Organization 2017). The reverse is true for individuals aged 15-19 years, among which the prevalence has been reported to be 3.8% and 3.3% for depression and anxiety, respectively (World Health Organization 2017). Evidence at a global level suggests that depression in particular is lower among the younger population than in older age groups (World Health Organization 2017).



Moreover, about 75% of the global burden of CMDs lies in low and middle-income countries (LMICs), with the majority of these not getting the care they need (Patel, 2011). This is referred to as the 'treatment gap', and it leads to an increase in the severity and morbidity of CMDs (Patel, Chisholm et al. 2016). According to the 2017 *Global Burden of Disease Study*, mental and substance use disorders constituted 7.97% of disease burden, resulting in 211.9 million disability-adjusted life years (DALYs), with CMDs contributing most of these (IHME, 2018). In 2015, 6.6% of disease burden was attributable to mental and substance use disorders with 162.4 million DALYs (Kassebaum, Arora et al. 2016). CMDs are also associated with lost productivity, societal burden, increased health costs, as well as caregiver burden on family (Patel, Chisholm et al. 2016). Finally, depression is known to increase the risk of suicide among the general population, with 788 000 people estimated to have died of suicide in 2015 alone (World Health Organization, 2018).

A similar burden is reported among adolescents suffering from CMD. Notably, the highest proportion of total DALYs associated with CMDs is found amongst 10-29 year-olds (Whiteford, Degenhardt et al. 2013). CMDs among adolescents have a significant bearing on human functioning and health (World Health Organization, 2017). For example, forty-six percent of adolescents in the United States who fail to complete secondary education, do so as a result of the presence of a psychiatric disorder (Vander Stoep, Weiss et al. 2003).

Other development concerns such as lower educational achievements have been found to be linked to poor mental health. This school dropout, in turn, lowers socio-economic status and employment prospects (Vander Stoep, Weiss et al. 2003, Myer, Stein et al. 2009). Depression is also a major risk factor among adolescents who commit suicide, with suicide being the second leading cause of death among adolescents (Windfuhr, While et al. 2008, World Health Organization 2017). The World Health Organization estimates global suicide rates of 10.5 for every 100 000 people (World Health Organization 2017). Suicide rates for Zimbabwean adolescents aged 15-19 stand at 8.9 per 100 000 people (World Health Organization 2019).

Also, if left untreated, CMDs among adolescents can have several psychological, physical and economic repercussions in adulthood. For example, depression in adolescence can manifest as an anxiety disorder, substance-related disorder, or bipolar disorder in adulthood (Fergusson, Horwood et al. 2005). A study conducted on how psychological disorders in adolescent girls influence adult physical health outcomes showed that untreated CMDs lead to physical health problems, substance dependence and increased susceptibility to health issues such as sexually transmitted diseases (Bardone, Moffitt et al. 1998).

Untreated depression among adolescents has also been found to be associated with unhealthy behaviours which can have negative effects on adherence to ARV medication (Mavhu, Berwick et al. 2013). Cognitive functions such as information processing, planning, problem-solving, and activation of adherence behaviours are all affected (Fisher, Amico et al. 2008). In a systematic review of 23 studies conducted in Sub-Saharan Africa, the likelihood of achieving good ARV adherence was 55% lower among those with depression symptoms compared to those without (Nakimuli-Mpungu, Bass et al. 2012).

Similarly, a study conducted in rural Zimbabwe found high levels of psychological morbidity among youths, which was associated with sexual risk taking (Langhaug, Pascoe et al. 2010). Sexual risk-taking exposes adolescents to contracting the HIV and other Sexually Transmitted Infections (STIs). Behavioural factors linked with mental disorders that affect sexual risk-taking include high rates of sexual contact with multiple partners, low adherence to condom use, injected drug-use or sexual contact with injecting drug users and unprotected sex between men (Kelly 1997). If no mental health interventions within the area are available this means that more resources have to be channelled towards behaviour change programs and treatment for HIV and STIs.

Adolescents make up a large percentage of the global population, constituting almost 30%, and close to 90% of adolescents reside in low and middle-income countries, owing to the high fertility rates in those regions (Sawyer, Afifi et al. 2012). Up to 75% of adult disorders have

their onset during adolescence (Patel, Flisher et al. 2007) and mental disorders account for most years lost to disability among young people (Gore, Bloem et al. 2011). It is therefore vital to address and prevent mental health problems in adolescence, to bring forth benefits for the present, for the future, and for the next generation (Patton, Sawyer et al. 2016).

### 2.3 Common Mental Disorders and the Treatment Gap in Zimbabwe

The population prevalence of depression or anxiety among adolescents in Zimbabwe is available albeit outdated. Information that is available focuses on the general population, specific regions, adolescents, and women. In a survey conducted in Manicaland, Zimbabwe, 9.6% of participants aged 15-54 years were found to have psychological distress (Tlhajoane, Eaton et al. 2017). In rural Zimbabwe, 51.7% of adolescents were found to be at risk of CMDs, whilst 23.8% were at risk of being severely affected (Langhaug, Pascoe et al. 2010).

In 2009, 63% of HIV positive participants aged 13 years and above within Harare were found to be at risk of CMDs, whilst 30% were at severe risk (Mavhu, Berwick et al. 2013). In an older study of 172 women in Harare, conducted between 1991 and 1992, 30.8% of women indicated having had anxiety or depression in the previous year (Abas and Broadhead 1997), whilst in another study conducted the following year, 55% of women who experienced a severe event or major difficulty became depressed (Broadhead and Abas 1998).

Despite the burden of disease of mental disorders and the consequences of untreated CMDs, the public mental health sector in Zimbabwe remains hugely under-resourced. Indeed, the population of 13 million in Zimbabwe depends on just 12 psychiatrists and 16 psychologists (Chibanda, Verhey et al. 2016, Chibanda 2017). Poor remuneration for mental health professionals, work-related stigma and hiring freezes have resulted in the emigration of mental health graduates and poor popularity of the mental health sector in Zimbabwe (Liang, Machando et al. 2016).

Zimbabwe has two acute psychiatric wards which also function as teaching hospitals, 4 acute psychiatric wards, 2 chronic facilities, 10 halfway homes and 2 forensic facilities (Liang, Machando et al. 2016). Mental health policies available to govern mental health in Zimbabwe include the Mental Health Act 1996, Mental Health Policy 2004, the Mental Health Strategy 2014-18, and Guidelines and Treatment Protocols for the Management of Common Mental Health Disorders in Primary Care 2012. However, according to the World Health Organization's (WHO's) policy on legislation, some of these are outdated.

Lack of adequate funding and resources means these policies, structures and institutions are not functioning or being implemented effectively (Kidia, Machando et al. 2017). Budgetary allocation is minimal with government channelling as little as 1% of the total health budget towards mental health and the bulk of donor funding (e.g., the President's Emergency Plan for AIDS Relief and the United States Agency for International Development), going towards HIV and tuberculosis programs (Liang, Machando et al. 2016).

Sakubva Hospital, a facility with a psychiatric ward, located in the Manicaland District has shut down due to drained infrastructure, whilst in functional mental health institutions, issues like overcrowding and lack of medication, food, water, bedding, and staff continue to be a problem (Liang, Machando et al. 2016). This translated into patients not receiving adequate care and treatment. Those in forensic facilities risk being stuck in prison for years as they await assessment which ordinarily should be done within 21 days of being admitted into the facility (Liang, Machando et al. 2016). In December 2017 the Government of Zimbabwe, however, announced that it had set up a mental health tribunal to assess incarcerated patients in prisons (Mananavire, 2017).

This lack of resources, poor budgetary allocation and drained infrastructure further contributes to the treatment gap in the country. Integrating mental health services into primary care, particularly through task-sharing, is recommended as a solution to bridge this gap (World Health Organization, 2007, World Health Organization, et al. 2008). Task-sharing

in the mental health context refers to the training of lay health workers to deliver basic mental health interventions while receiving ongoing support and supervision by mental health specialists (Patel 2012). An example of a task-sharing evidence-based approach that has proven to be effective in treating CMD in Zimbabwe is the Friendship Bench.

## 2.4 The Friendship Bench Intervention

The Friendship Bench is a brief psychosocial community-based intervention aimed at helping reduce the burden of CMD among both adults and adolescents through task-sharing (Chibanda, Mesu et al. 2011). The intervention includes six, 30-45 minute individual sessions of problem-solving therapy (PST) aimed at reducing symptoms of depression and anxiety (Chibanda, Mesu et al. 2011). The intervention is delivered by trained and supervised lay health workers (LHW), on a bench in the property of primary care clinics in Harare (Chibanda, Mesu et al. 2011), and services both adults and adolescents. Support groups are also formed which clients attend as part of the intervention. Peer-led support groups, known as Circle Kubatana Tose (CKT), provide an open space to talk and promote income-generating activities. The Friendship Bench ran for over eight years as a pilot programme in three City of Harare primary care clinics (Chibanda, Verhey et al. 2016).

Clients are identified for the Friendship Bench through clinic morning talks conducted by LHWs or through community mobilization. Community mobilization involves the LHWs going out into the community which services their respective clinics. The LHWs go door-to-door or address clusters of people at common meeting places. They give psychoeducation on CMDs and direct prospective clients to the Friendship Bench. Normally the mobilization is also done for other programmes such as immunization or HIV testing and counselling. Both the clinic morning talks and community mobilization are done one-on-one and for groups. Clients are also sourced through referrals from the clinics' Sister in Charge.

Screening is then done by a LHW at a Friendship Bench using the Shona Symptom Questionnaire (SSQ) 14, which is a 14-item dichotomous, locally validated screening tool for

common mental disorders (Patel, Simunyu et al. 1997). Clients who screen positive are referred for their first sessions of PST, after which they are invited for a subsequent sessions, with a maximum of six sessions (Chibanda, Mesu et al. 2011, Chibanda, Bowers et al. 2015, Chibanda, Weiss et al. 2016). The SSQ 14 is re-administered during the 4<sup>th</sup> session to determine any changes in SSQ score (Chibanda, Bowers et al. 2015, Chibanda, Weiss et al. 2016). After re-administration of the SSQ 14, the client is invited to attend the support group (CKT) if there has been a reduction in symptom score. If there are no changes in symptom score, the client is referred to a higher level of care.

A randomized control trial (RCT) conducted among 24 primary care attending adults showed that the Friendship Bench intervention is effective in treating CMD (Chibanda, Bowers et al. 2015). Within the RCT, 573 randomized clients aged 18+ with CMD took part and the intervention group indicated considerably lower symptom scores after six months, compared with the control group who got usual care (Chibanda, Weiss et al. 2016). At follow-up, among the intervention group, there was also a lesser number of those having reported high rates of suicide previously (Chibanda, Weiss et al. 2016).

The success of the RCT led to the scale-up of the Friendship Bench to over 60 clinics in Harare, Chitungwiza and Gweru in 2016 (Chibanda, Verhey et al. 2016). The scale-up process included a needs assessment and sensitization of all stakeholders, devising and adjusting training material, training of facilitators and future supervisors, the training of 300 LHWs in the three cities, the pilot and then finally implementation and evaluation (Chibanda, Verhey et al. 2016, Chibanda 2017). Data collected from the beginning of the scale-up period to date indicates that at least 5% of the Friendship Bench clients are adolescents. Across all sites at least 1769 adolescents visited the Friendship Bench within a year.

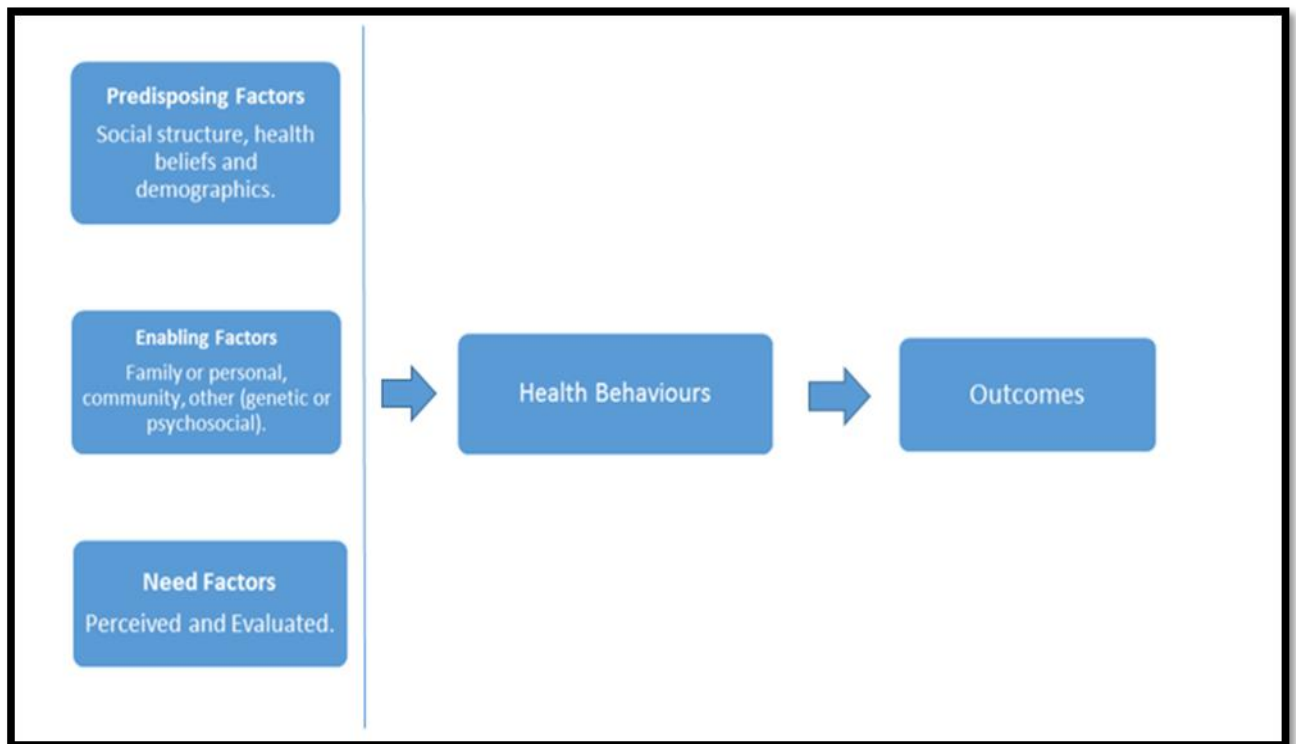
However, despite effective task sharing interventions and treatments being available, most adolescents with depressive disorders do not receive any mental health services (Michael and Crowley 2002, Merikangas, He et al. 2011). Process data suggests that many of the clients

referred to the Friendship Bench do not return for a second session, especially adolescents. At one clinic in Harare, one of the Friendship Bench's implementing clinics, 4.2% (n=43) of 1027 clients seen were adolescents. Only 1.7% of these 1027 clients who used the service returned for at least a second session, none of whom were adolescents. This pattern of individuals not accessing services or poor retention in treatment or sessions is seen in other LMICs as well, even when mental health services are available (Wang, Aguilar-Gaxiola et al. 2007).

## 2.5 Theoretical Framework

Various frameworks have been used in previous studies to investigate the barriers and facilitators to health care, for example, Rosenstock's health belief model (HBM) (Rosenstock 1974), Suchman's seeking care model (Geertsen, Klauber et al. 1975), Mechanic's illness behaviour model (Mechanic 1962) and Andersen's behavioural model of health service use (Andersen 1995). This study will make use of Andersen's model which is one of the most widely acknowledged models of health service use. Andersen's model was chosen as the framework for this study as it has been found to include powerful predictors for utilization of health services at all levels, which include individual, family or community levels (Andersen, 1995). Unlike other models, Andersen's model not only examines human behaviour, but also adherence to treatments and the relationship between the patient and health care provider.

Andersen (1995) developed the Behavioural Model of Health Services Use in 1968. Since then, the framework has gone through four phases of improvement. The aim of this model is to ascertain circumstances that either facilitate or hinder the use of health services. The belief is that an individual's access and use of services is a function of three population characteristics, namely; predisposing factors, enabling factors and need factors (Babitsch, Gohl et al. 2012). See Figure 1 below for a graphical representation of these phases.



**Figure 1 Conceptual framework of health services use (Adapted from Andersen, 1995).**

Predisposing factors refer to the socio-cultural characteristics of persons that are present before their illness. Social structure, health beliefs and demographics all fall under predisposing factors. Social structure as a factor encompasses education and/or occupation, ethnicity, social systems, social interactions, and culture. Attitudes, values, and knowledge that people hold in relation to and towards the health care system are regarded as health beliefs. Age and gender also directly influence use of health services.

Enabling factors are also known as the logistical aspects related to attaining care. Sub-factors of enabling factors include personal or family factors, community factors as well as other possible additions such as genetic characteristics and psychosocial factors. Personal or family factors revolve around the means through which people access health services, their income levels, whether they have health insurance, if they have consistent access to care, if any travel is involved in getting to the health provider and finally the quality of the individual's social relationships. Within the community, available number of health personnel, facilities available and waiting time are key in influencing health service utilization.



Need factors are the most common reason why people use health services. Both practical and health complications result in the need for use of health services. Need factors include perceived need and evaluated need. Perceived need refers to how people regard their health and ability to function, as well as their experience with signs of illness, pain, and worries about their health. Perceived need also includes whether or not people see their complications to be of crucial importance and level to seek the help of a professional or not (Andersen, 1995). This helps in understanding engagement to a prescribed medical schedule. Evaluated need, on the other hand, offers a representation of professional judgment about people's health status and their need for medical care, also how much care as well as the nature or type of care that will be received after visiting the medical care provider (Andersen, 1995).

With regard to the Friendship Bench, satisfaction and utilization of the service may depend on the individual's interaction with the community, the LHWs and the clinic system. These factors would be considered changeable and could facilitate access (Andersen 1995). They would include factors like health beliefs, which can be shifted through health promotion activities. However, some factors are not changeable, such as demographics or distance to clinics. This model has also been used in low-income settings previously (Davidson, Andersen et al. 2004), which makes it fit to use in Zimbabwe.

The low- and middle-income contexts where this model has been used include the rural setting of Guangxi, China in a survey of 4634 participants looking at utilization of services such as physician visits and hospitalization (Yan-Ning-Li, 2016). Other low- and middle-income settings where the model has been utilized include the Kersa district in Eastern Ethiopia to determine uptake of antenatal services among 1294 women aged 15-94 (Tesfaye et al., 2018) and in South Eastern Nigeria among 3065 adolescent girls to examine use of reproductive health services (Azfredrick, 2016).

## 2.6 Barriers and Facilitators to Retention

Literature presents several reasons why people do not remain engaged in mental health services. Some of the reasons for not remaining engaged include lack of transportation (Sacks, Greene et al. 2015), waiting times (Oruche, Downs et al. 2014, Brown, Rice et al. 2016), and negative past experiences, while some reasons for staying engaged include pleasant past experiences, evidence of feeling better and respect from and trust of a service provider (Fischer, et al. 2016).

There are known associations between demographic factors such as gender and race or ethnicity and mental health service use. Males were found to be at higher risk of dropping out of treatment in one South African study (Bruwer, Sorsdahl et al. 2011). In New York City there were varying levels of mental health service use amongst non-Hispanic blacks, Hispanics, Asians, and non-Hispanic whites depending on the metropolitan area (Siegel, Wanderling et al. 2013). In one study examining behavioural healthcare service use of 23,601 children aged 5-17, Hispanic children had significantly lower use of in-school services than white children (Locke, Kang-Yi et al. 2017), whilst in another study African-Americans were more likely than whites to access school-based services (Husky, Kanter et al. 2012). In these examples, race or ethnicity is associated with both poorer and better use of services, compared to other groups.

Age is another factor associated with poor access to services. A South African study aimed at examining both structural and attitudinal barriers to treatment initiation among adults with mental disorders found that younger respondents were at high risk of early treatment drop-out (Bruwer, Sorsdahl et al. 2011). In another study of children aged 5-10 and adolescents aged 11-19, adolescents were found to access mental health services more than children (de Haan, Boon et al. 2012). A quantitative study on access to non-inpatient services indicated higher treatment intensity rates for white youths versus black and Hispanic adults (Siegel, Wanderling et al. 2013).

For several studies, characteristics of the service provider seemed to have a huge bearing on their coming for sessions or not coming back (Gulliver, Griffiths et al. 2010, Kozloff, Cheung et al. 2013, Oruche, Downs et al. 2014, Eliacin, Rollins et al. 2016, Fischer, McSweeney et al. 2016, Rice, Telford et al. 2018). Among African-American war veterans aged 18 years and above, it was found that the service provider being able to establish a human connection during the first visit was important in retention of veterans in mental health services (Eliacin, Rollins et al. 2016). For homeless Canadian youth, building a foundation in terms of participation in mental health services was effective through building a relationship with the provider over time (Kozloff, Cheung et al. 2013, Eliacin, Rollins et al. 2016). A practitioner who was easy to get along with was also beneficial (Kozloff, Cheung et al. 2013).

In one descriptive qualitative study involving 12 teens, negative staff attitudes led to treatment dropout whilst having respectful staff who involved teenagers and their parents and communicated timely helped to decrease dropout (Oruche, Downs et al. 2014). Looking at perspectives of rural veterans, they echoed the need to feel respected in addition to feeling cared for, and growing trust between provider and client was a facilitator to engagement (Fischer, McSweeney et al. 2016). Young Australian males aged 12-17 found maintaining confidentiality and male gender of the service provider to be an important facilitator (Rice, Telford et al. 2018). In a South African study, the likelihood of terminating treatment was reduced if the service provider was a psychiatrist or other mental health specialist, versus general medical services (Bruwer, Sorsdahl et al. 2011).

Directly related to the characteristics of a service provider is the participants' or clients' past experience with a service or service provider (Gulliver, Griffiths et al. 2010, Adler, Britt et al. 2015, Sacks, Greene et al. 2015, Brown, Rice et al. 2016). If participants had good experiences with a service, they would return for more sessions, whilst poor experiences meant clients did not come back for more sessions.

Waiting times or waiting lists act as barriers when it comes to engagement of mental health services (Oruche, Downs et al. 2014, Brown, Rice et al. 2016). A systematic review of barriers and facilitators among at risk youth indicated that one vulnerable group – homeless youth – found waiting lists to be a barrier in four studies, whilst rural students found waiting lists to be too long (Brown, Rice et al. 2016). Another study indicated long waits at counselling appointments affecting participation, particularly regarding clinic records and delays in obtaining prescriptions (Oruche, Downs et al. 2014). Contrary to this, a study among youth receiving multi-systemic therapy indicated that there was no significant association between waiting time and premature treatment termination (Westin, Barksdale et al. 2014).

Stigma surrounding mental health issues is another barrier and can lead to poor retention and uptake of mental health services or once again reluctance in seeking mental health services (Andrade et al., 2014). Stigma directed towards people with mental health issues often emanates from little or poor knowledge surrounding mental health. Stigma and feeling labelled was a barrier to engagement for most disadvantaged young people, e.g., homeless young people with mental health problems and substance using young people (Brown, Rice et al. 2016). Focus group discussions with homeless youths indicated self-stigma as well as stigma from service providers as a factor influencing service use (Kozloff, Cheung et al. 2013).

Symptom severity or co-morbid disorders is also another factor influencing retention (Merikangas, He et al. 2011, Adler, Britt et al. 2015, Brown, Rice et al. 2016, Fischer, McSweeney et al. 2016). In an interviewer-administered survey of 6483 adolescents with a presence of co-morbid disorders, severe impairment and disorder severity were strong predictors of retention (Merikangas, He et al. 2011). In a study of Asian and Latino immigrants, it was found that having more psychiatric disorders was independently associated with higher probability of mental health service use in the Latino group (Kim, Loi et al. 2011). However contrary to this, one study of rural veterans indicated that improvement in symptoms encouraged participants to continue coming back for more sessions (Fischer, McSweeney et al. 2016).

Several of the above factors were echoed in studies looking at parents and providers' perspectives. Families of children with serious emotional problems faced barriers such as rurality, stigma, embarrassment, transport, isolation and poverty, whilst a tight-knit religious community (supportive environment) was found to be instrumental in facilitating service use (Pullmann, VanHooser et al. 2010). However, caregivers also felt that a tight-knit and religious community also presented as a barrier as some respondents felt they would be judged for their families' shortcomings or mental condition (Pullmann, VanHooser et al. 2010). As suggestions for decreasing treatment drop-out among adolescents attending a community health clinic, parents suggested provision for transportation, education and support groups for caregivers and appointment reminders (Oruche, Downs et al. 2014).

Some not so frequently occurring barriers influencing retention include language used at the service, unavailability of insurance (Kim, Loi et al. 2011) as well as transportation challenges and lack of time (Sacks, Greene et al. 2015). In a South African study, absence of health insurance increased the odds of dropout (Bruwer, Sorsdahl et al. 2011). A similar finding was reported among an American sample of young adults (Carson, Le Cook et al. 2010). While there are several studies on barriers to care, facilitators are generally under-researched.

## 2.7 Rationale for Study and Objectives

A review of the literature has demonstrated that adolescence is a critical phase and that it is important to give attention to adolescent mental health, as it has an important bearing on future functioning in adulthood. Despite task-sharing psychosocial interventions becoming available in LMICs to address the mental health treatment gap, there remain barriers to care, among both adults and adolescents. Available research suggests that some barriers to retention specifically among adolescents include age, gender, lack of transportation, waiting times, stigma and negative past experiences, to mention a few. Facilitators include age, pleasant past experiences, evidence of feeling better, respect from and trust of a service provider, and subsequent ability to create a relationship or rapport with the provider.

The aim of the present study is thus to explore adolescents' barriers and facilitators to retention in the Friendship Bench, a psychosocial intervention in Zimbabwe. This will contribute to improving retention and mental health outcomes of adolescents, as well as contribute towards reducing the burden of CMDs. Additionally, the results of this study will help provide information that will assist in the formative work of the 'Youth Friendship Bench' (YouFB) package.

# Chapter 3: Methods

This study aims to explore the barriers and facilitators that adolescents with common mental disorders (CMDs) experience in retention to a psychosocial intervention. This chapter will explain the research design, setting, participants, sampling procedures, analysis of data and ethical considerations. This study meets the criteria outlined in the “Consolidated Guidelines for Reporting Qualitative Research” (COREQ) (Tong, Sainsbury et al. 2007). See Appendix K for the COREQ checklist.

## 3.1 Design

The research study involved a qualitative study of adolescents who had visited the Friendship Bench between June 2016 and December 2017. Semi-structured interviews were employed with open-ended questions guided by Andersen’s framework, to get an understanding of the barriers and facilitators that adolescents experienced in adhering to the Friendship Bench during this time.

## 3.2 Setting

The research took place in urban Harare, the capital of Zimbabwe. According to the 2012 census, urban Harare is a low-resource setting that has a population of over 1.5 million. Most of the key public services in the capital city are run and administered by the City of Harare. These include health services, and thus the city runs and administers key health institutions, including clinics (Pindula, 2018). The clinics service large populations from socio-economically disadvantaged areas (Chibanda, Bowers et al. 2015).

The ‘City Health’ is divided into two zones, headed by Deputy Nursing Managers. These are further divided into eight districts which are led by District Nursing Officers or District Health Promotion Officers (City of Harare 2016). Each district is made up of several clinics and the clinics are headed by Sisters in Charge. The healthcare facilities range from polyclinics, satellite clinics and hospitals, which provide a variety of services (City of Harare 2016).

The clinics vary in size based on the clinic's catchment area, staff complement and services available. Polyclinics have a wide array of services offered which include outpatient, opportunistic infection, maternity and family health services whilst satellite clinics only offer a limited number of those services. Polyclinics have a larger staff complement than satellite clinics and service larger numbers of people than do satellite clinics. This study was conducted at five City of Harare primary healthcare clinics where the Friendship Bench is currently running. Of the five clinics, two were polyclinics whilst three were satellite clinics.

### 3.3 Screening and Friendship Bench Referral

As mentioned above, all clients of the Friendship Bench are screened by a LHW at the clinic, using the SSQ-14, a screening tool which was locally validated to identify individuals at risk of common mental disorders (Patel, Simunyu et al. 1997). Individuals who score or above the recommended cut-off of 9 are referred immediately for their first session of PST, after which they are invited for a second session and subsequently for more sessions until they get to the sixth session (Chibanda, Mesu et al. 2011, Chibanda, Bowers et al. 2015, Chibanda, Weiss et al. 2016).

The majority of clients who screen positive on the SSQ-14 attend the first session. Clients are also referred for a first session if they score below 9 but show signs of distress and the LHWs feel they need counselling. Clients who score high on the SSQ-14, are suicidal, or present with hallucinations (known as 'red flag' clients) are also referred to a higher level of care for further assessment (Chibanda, Bowers et al. 2015, Chibanda, Weiss et al. 2016).

### 3.4 Participants

#### *Eligibility Criteria:*

Participants eligible for the study were adolescents who had attended one of the five clinics, had been referred to the Friendship Bench intervention and had attended at least one session. All participants had to be aged 15-17 at the time of accessing the service and were



either Shona or English speaking. Participants who failed to present written consent and assent were excluded.

### 3.5 Sampling Procedures and Recruitment

Purposive sampling (Kothari 2009) was used for sampling clinics from which participants were recruited, based on ease of access to the researcher. This non-probability sampling method is often used when the researcher has limited time and resources (Etikan, 2016). Approximately 20 participants in total were to be recruited. More adolescents were to be recruited to reach theoretical saturation if required. Interview notes and a preliminary analysis run during data collection assisted in helping to make this decision. I aimed to balance the total number of adolescents in terms of sex and age.

Participants were recruited on the basis of the inclusion criteria and the number of sessions attended. Results from the Friendship Bench RCT indicate that for the intervention to be effective, a client should have attended a minimum of three individual sessions (Chibanda, Mesu et al. 2011). Thus, participants were assigned to either Group A (engaged participants, who have attended three or more sessions) or Group B (non-engaged, who have attended one to two sessions). The intention was to have a balanced sample of 10 participants in each group giving a total of 20.

Eligible participants were identified through the Friendship Bench clinic registers using SSQ scores and age. Participants were then contacted by telephone, briefed on the study and invited to the clinic for a detailed explanation of the study, its expected risks, benefits and procedures, and then the participants were invited to ask any questions concerning the study. Due to difficulty in finding participants through clinic records alone, an alternative recruitment procedure was put in place, which included getting help from the LHWs.

The LHWs at each of the clinics were trained to approach participants during their community rounds. Information was provided to the LHWs on how to invite participants to the clinic, and what to communicate or what not to communicate to participants. Care was taken to ensure

that LHWs were clear to the participants about being invited to take part in a research study and that this was entirely voluntary. The importance of confidentiality was emphasized to the LHWs. The LHWs also have experience in following up clients in the community and inviting them to the clinic for other programs. Despite this being a research and not service provision, the methods were transferable.

The age of consent in Zimbabwe is eighteen years (Bwakura-Dangarembizi, 2012). Once clients agreed to participate, they were invited to come to the clinic to have the study explained to them. After explanation, clients were issued with assent and/or parental consent forms (see Appendix A & B) for them to take home for parents or guardians to sign. A guardian refers to a person or relative who has custody of the minor. To identify the legitimacy of the guardian, proof of guardianship was to be presented if available. Signed forms were returned when the participants came back to the clinic for their scheduled interview. Where possible young people's parents were present during the consent process. For participants who had been referred at age 17, but were now aged 18 and above, only their consent was required.

### 3.6 Study Procedure

Care was taken to ensure there was no disruption of school attendance for those adolescents still in school, thus interviews were scheduled for when adolescents were available. Interviews were conducted in a space which was convenient to the participant or at the participant's local clinic grounds, outside in a private space, and lasted approximately 30 minutes each. The adolescents were given the option of whether to be interviewed in Shona or English.

Participants were interviewed by two female independent qualitative interviewers who are fluent in both Shona and English, and both have an Honours degree in Psychology and at-least two years' experience conducting qualitative interviews. The flow of the interviews was monitored through sit-ins and going over recordings to check that the interview schedule was being followed. Interviews were recorded using a voice recorder and notes were taken during the interview to capture non-verbal cues. Participants were compensated for transport costs.

### 3.7 Measures and Instruments

Semi-structured interviews were employed, using themes derived from Andersen's Behavioural Model of Health Services Use (Andersen 1995), and incorporating questions referring to predisposing factors (socio-cultural characteristics), enabling factors (logistical aspects) and need factors (functional or health problems). The interview guide was translated by myself into Shona then back translated by one of the interviewers into English. Probes were used, when necessary, to get a deeper understanding of barriers and facilitators to adolescents' retention to the Friendship Bench (see Appendix C for the interview guide). A pilot interview was conducted with one participant to test the instrument and the pilot results were included in the final analysis and write-up. A few minor changes were made to the instrument following the pilot.

I initially transcribed the audio interviews verbatim and then went on to translate them into English in the event they were in Shona. Following this, all original Shona interviews were back translated into Shona from English, using another translator. This was done to ensure accuracy and to establish that the original meanings had been retained.

### 3.8 Data analysis

Data was analysed using thematic analysis (Hancock, Ockleford et al. 2009) with Nvivo 12 Pro. The initial phase of the analysis involved reading through and familiarizing with the transcripts. After familiarization with the transcripts I searched for initial themes which fed into Andersen's Behavioural Model of Health Service Use framework. This was followed by more reading and searching of themes. A second coder was involved in a similar process and the two sets of coded transcripts compared and amended accordingly. Other themes not covered by Andersen's model were also considered when I analysed the transcripts. Data coded incorrectly or in the wrong nodes were corrected whilst some data was combined under broader themes.

### 3.9 Reliability and Validity of Collected Data

To ensure validity and reliability of data other researchers were included to reduce bias – the interviews were done by two interviewers. Another researcher and I were involved in the transcription, translation and analysis of the data.

### 3.10 Ethical considerations

Permission to access patient files was granted by the City of Harare Health Department. Permission to carry out the study was requested from the HREC (Human Research Ethics Committee) of the Faculty of Health Sciences, University of Cape Town and the Medical Research Council of Zimbabwe (MRCZ).

Once approved by the HREC at the University of Cape Town, the English versions of both parental consent and assent forms were translated into Shona. The Shona versions were then back-translated into English by a second person to ensure that no information had been omitted. Parental consent and assent forms were signed by parents or guardians and adolescents to give permission to take part in the study. Adolescents above 18 only needed to provide their consent. All adolescents provided the appropriate forms before they were interviewed. A statement for consent to audio record the interview was included in the consent form. Participants were informed that they were free to withdraw at any point if they felt the need to.

There was minimal risk and discomfort anticipated in taking part in this study because it was comprised of one qualitative interview. However, if the participant felt that a question was sensitive in nature and would cause discomfort, they did not have to answer. The participant also had the option to stop the interview whenever they felt like it. When participants experienced emotional distress during the interview, they were referred to the Friendship Bench for counselling.

Only the team directly involved in the research had access to the study information. Every team member involved in the study was required to sign a confidentiality agreement. All information to be disseminated was de-identified and participants were allocated patient

identification numbers to keep their identity anonymous. As compensation for taking part in the study, participants received three United States dollars to cover transport costs as well as a snack and something to drink. Transport reimbursement of three United States dollars was also provided when adolescents reported to the clinic to collect consent and assent forms.

Participants were given the option to receive the study results through email or registered mail. Consent forms, recordings, transcripts and written notes from the interview were all kept in a locked cabinet in the researcher's office. All other data pertaining to the study was stored in the researcher's laptop which is password protected. Consent forms are to be kept for three years after the completion of the investigation as stipulated by the Medical Research Council of Zimbabwe (MRCZ). All other data pertaining to this research will be kept until the end of the study and then destroyed.

# Chapter 4: Results

The results will be presented as follows: firstly, the characteristics of study participants, followed by the perceived barriers and the facilitators to retention to the Friendship Bench intervention. Perceived barriers and facilitators will be presented under the following sub-themes of predisposing factors, need factors and enabling factors, following Andersen's (1995) Behavioural Model of Health Services Use.

## 4.1 Characteristics of the participants recruited

A total of 13 participants aged 15-17 were interviewed from five sites for this study, including nine females and four males. The process of interviewing discontinued at the 13<sup>th</sup> interview due to the difficulty in identifying and recruiting participants. One participant was excluded from the analysis after the interview as the participant was mistakenly interviewed despite not meeting inclusion criteria. The participant had visited the Friendship Bench within the year 2018 and not the period June 2016-December 2017. As a result, a total of 12 interviews were transcribed verbatim and then translated into English.

Most participants were aged 17 with only three aged 16 and one aged 15. The majority of participants came from a Shona ethnic background and just two were of Mozambican descent. The majority of participants were single and unmarried. More detailed demographics are shown in Table 1. A total of 10 participants were in the non-engaged group, having attended 1-2 sessions only. Two participants were in the engaged group and attended 3 or more sessions. Family problems were the most common initial problem presented by participants during their first session at the Friendship Bench.

**Table 1: Participants' socio-demographic and clinical information**

<b>Case Classifications</b>	<b>N</b>
<b>Age:</b>	
15	1
16	3
17	8
<b>Gender:</b>	
Female	8
Male	4
<b>Ethnicity:</b>	
Shona	10
Mozambican	2
<b>Relationship Status:</b>	
Single	10
Married	2
<b>Occupation:</b>	
School	6
Work	3
None	3
<b>Clinics:</b>	
Satellite Clinics	5
Polyclinics	7
<b>Presenting Problem:</b>	
Family	4
Bereavement	2
School	1
Religion	1
Relationship	1
Substance Use Disorder	1
Financial	1
Legal	1
<b>Referrals:</b>	
Hallucinations	1
Suicide ideation	3
<b>Sessions:</b>	
1 session	7
2 sessions	3
3+ sessions	2

#### 4.2 Barriers and facilitators to retention to a psychosocial intervention

#### 4.2.1 Predisposing Factors

Predisposing factors refer to sociocultural factors that exist before one is diagnosed with a common mental disorder that influence retention to a psychological intervention. In the present study mental health beliefs (attitudes, knowledge and values) and social structure (particularly social systems and social interactions) were highlighted by participants as predisposing factors that influenced their retention to the Friendship Bench.

##### **Mental health beliefs**

To begin with, knowledge on mental health beliefs was the most frequently reported predisposing factor to retention in the Friendship bench. Prior to participating in the Friendship Bench, 9 participants mentioned they were unaware of common mental disorders. This lack of knowledge regarding depression and anxiety was described as prevalent among their peers and other members in the community. Further, this lack of knowledge and understanding of depression among peers was implicated by a number of participants in their decision to disclose to their friends that they were receiving counselling. This is encapsulated by one participant who said:

*“Like for me, the friends I play with they don’t even... I can’t even say these issues to do with depression, I can’t say they really know how these things go.”*  
(Participant\_10\_Non-engaged)

However, after receiving services offered by the Friendship Bench, 10 participants reported high levels of mental health literacy regarding depression. Participants seemed well aware of what depression was as well as what could cause depression and its effects on them personally or for other people. Some causes of depression that participants mentioned were: losing one’s parents, failing at school, an unpleasant home situation (e.g. parents fighting when you are present), having no money for school fees, staying with an abusive step-parent, and rape and divorce. Some effects of depression from participants’ perspectives included thinking too much, losing confidence, weight loss, isolation, suicide and feeling troubled and



alone. Having this knowledge allowed participants to acknowledge that depression was a condition and thus enabled them to seek help and continue getting help. Some participants described depression as follows:

*“Depression is stress. Things that will be troubling your mind and you are constantly thinking about what is troubling you. So the things that trouble you are the ones that lead you to think too much.” (Participant\_13\_Non-engaged)*

*“Depression is about...is a point whereby, I think is a point whereby one can be affected with a certain situation, and then they get depressed from it.” (Participant\_02\_Non-engaged)*

*“The way I think about this thinking is that depression and anxiety is something that eats you up inside, all the while you are thinking these things are important, but these things do not even matter. That is my thinking.” (Participant\_04\_Engaged)*

*“Depression, I can say it is an illness where you think too much.” (Participant\_09\_Non-engaged)*

Knowledge of depression was received from various sources. A total of 9 participants mentioned they had first heard about depression from LHWs at the Friendship Bench. For the two participants who had heard about it before coming to the Friendship Bench, this was from school and church. About 9 participants believed depression was treatable. Receiving knowledge from these sources about depression, and the belief that depression was treatable, facilitated Friendship Bench service use. One participant mentioned:

*“...depression can be treated provided you have people like the LHWs who sit down with you and really explain because depression and anxiety is an illness. When you find someone who has it, you would not have had someone to sit down with and share with because many people who suffer from depression or anxiety do not have anyone say to spend like five minutes with them just talking.” (Participant\_04\_Engaged)*

### **Social systems**

The second predisposing factor that was reported to influence retention in the Friendship Bench programme is social systems. As a predisposing factor, social systems are diverse and complex, because each participant had a unique support system. There were 8 participants' who received both encouragement and support to continue to access the services of the Friendship Bench. Below is a quote illustrating that:

*“I told my grandmother, she understood and said you can go – she did not refuse at all because she realized it could actually help me ahead.” (Participant\_11\_Non-engaged)*

The majority of participants had also disclosed to one person or the other that they were coming to the Friendship Bench, however the source and extent of the support varied. Social support came from both friends and workmates.

One participant's workmate (a maid) encouraged her to attend sessions but at the same time advised her against attending. The workmate said this could potentially affect her work relationship with her employers as she would need to go during working hours and was not allocated any off days. This particular situation hindered her from attending sessions. Below is her narrative:

*“She (workmate) encouraged me but she would tell me that if I left the house I may come back and the situation here has changed, you know the living arrangement here and so on.” (Participant\_09\_Non-engaged)*

#### 4.2.2 Need Factors

##### **Perceived Need**

Perceived need, which is the way individuals experience signs and symptoms of illness (daily activities, psychological distress, depressive symptoms and perceived health), emerged as a contributor to accessing and retention to the Friendship Bench.

All participants who received the Friendship Bench service saw the need to return to the Friendship Bench for counselling due to their experience with depressive symptoms and also because the symptoms the LHW brought up resonated with the way the adolescent was feeling at the time they first came to the bench. A common response among participants was that the LHW was correct in the evaluation done of the participant’s mental state, often because of a problem they were going through. One participant said that the LHW had seen that he was troubled:

*“She realised I was over-thinking and my thoughts were not in one place, then she started to talk to me bit by bit, counselling me and all.” (Participant\_04\_Engaged)*

Participants also spoke about their history with depressive symptoms, explained periods when they believed they had depression in the past and described symptoms they were experiencing around the time they first came to the Friendship Bench. Acknowledgement of symptoms experienced was key in adolescents staying engaged within the Friendship Bench. One orphaned participant was left to care for her younger brother after both her parents passed away. She experienced insomnia:

*“Let’s say in the evening right? In the evening when we are now sleeping – I would fail to sleep then end up sleeping at about 9/10 – I would just be sitting, and my little brother would be sleeping. I would then start to think – will my younger brother ever end up going to school? Now he is nine years old; he is not attending school.”*  
(Participant\_01\_Non-engaged)

Other participants also described their experiences with depressive symptoms. These experiences with symptoms demonstrate the acknowledged need to get help and attend sessions:

*“I have once experienced depression. Like when my father’s mother passed away, I experienced depression. It affected everything – my life, my schooling...”*  
(Participant\_02\_Non-engaged)

*“...my thinking before I came was a lot, I was always thinking about what to do...”*  
(Participant\_03\_Engaged)

*“I was the kind of person who was always troubled. There was a question I always had in mind – so in having these thoughts I began smoking marijuana and sort of drinking broncleer and alcohol.”* (Participant\_04\_Engaged)

In some instances, participants felt that the sessions they received were sufficient to address their needs. Four participants reflected on having felt better, relieved, encouraged and comforted after attending just 1-2 sessions at the Friendship Bench. Below are some narrations from participants after one session:

*“...when I sat with the grandmother on the bench it helped me a lot such that everything that I used to think about a lot from that point I do not think about a lot of it anymore.” (Participant\_01\_Non-engaged)*

*“When she counselled me I felt like something was removed from me, a burden which was pushing me down and I felt relieved...” (Participant\_08\_Non-engaged)*

*“It was enough. However, I can say that if something troubles me I will come back. It is helpful...it’s just I never had any other problems, moving forward. However, I left in November that is when I left this place, so there was nothing.” (Participant\_10\_Non-engaged)*

Although self-help was not a barrier as such, 5 adolescents had found their own ways to deal with their problems or negative thoughts, and thus did not feel the need to return to the Friendship Bench. Also though the majority of adolescents acknowledged they needed help – this often was not in the form of attending sessions at the Friendship Bench. Despite participants expressing the need to attend counselling sessions, there were other enabling factors such as community, family and personal factors which also influenced retention into the Friendship Bench.

#### 4.2.3 Enabling Factors

Enabling factors are logistical factors which are all-encompassing of community factors, family or personal factors as well as psychosocial factors. The analysis identified both personal, family, and community enabling factors.

##### **Personal Factors**

Conflicting priorities including school, sporting activities or work and other reasons to visit the clinic were the main enabling factors identified at the personal level. Engagement in school,

sporting activities or work by 9 participants often made it difficult to access services as they conflicted with the Friendship Bench operating hours. Participants were either in school or working, only three were not engaged in work or school. The 6 in school indicated school was full time and that they failed to return due to school obligations and having difficulty balancing time due to many commitments. Below are two quotes illustrating this:

*"I did not manage, because I was at school." (Participant\_02\_Non-engaged)*

*"There were days when I was doing sporting activities; it was hard to balance the time..." (Participant\_03\_Engaged)*

One participant who was working spoke about the difficulty of leaving work to come to the clinic due to rigid working hours. The participant, a live-in maid, mentioned she would start work as early as 4 am and finish at 6 pm. In addition to this, her working conditions were strict and did not allow her to leave and come back as she pleased. This is shown in the quote below:

*"I was thinking if this guy just leaves the house I can then leave as well and rush there to the clinic. However, he will be there... he just leaves for about two mins (short time) and goes to the shops and returns... because of work and because of what will be happening I can fail to find the time". (Participant\_09\_Non-engaged)*

The other 3 participants forgot or failed to come back for subsequent sessions due to other commitments. One elaborated on this:

*"For me to not come back, some days I would forget, sometimes I would have been told to come somewhere else, but I would just forget then when that day passes I then think that time I was told to come there by the grandmothers." (Participant\_01\_Non-engaged)*

Another participant mentioned not having been invited back for another session or rather that he may have been invited but forgot.

*“No they did not ask me... Maybe they did invite me and I forgot.”*  
(Participant\_05\_Non-engaged)

Another important facilitator was having other reasons to visit the clinic, thus making it easier to return to the Friendship Bench. Six participants had reasons for regularly visiting the clinic. These included coming to the clinic to collect a grandmother’s medication, accessing the clinic area to pay water bills (the clinic and the municipal office are within the same grounds), accompanying someone else, and bringing their own or others’ babies for check-ups.

*“I myself, when I come to the clinic I normally come to collect my grandmother’s medication. (Participant\_11\_Non-engaged)”*

*“...the second time I came back I joined that program. My aunt was coming to the baby clinic for immunization, so we then just came together. When she came to get shots for the baby then I sat with ...I forgot the name, I sat with the LHW and we explained and explained.” (Participant\_04\_Engaged)*

*“I’ll be bringing the baby.” (Participant\_03\_Engaged)*

### **Family factors**

Family support, or lack thereof, from parents, in-laws, a spouse, grandmother for example, was identified as an important factor contributing to participants’ retention in the Friendship Bench. Given that the participants in the present study were adolescents, all cases were dependent on their parents or other caregivers, in-laws, a husband or employer to obtain

access to the services offered at the Friendship Bench. Indeed, some participants were orphans or had been left behind by their parents as children and so lived with extended family members, while others lived with a single or both parents. However, two participants reported living with their husbands and in-laws.

Of the 12 participants 7 told family members or friends and described experiences where they received encouragement and support to continue to access the services of the Friendship Bench. Part of this encouragement seemed to come from the caregiver wanting to hand over the problem to someone else. One participant who told her aunt about receiving services at the Friendship Bench narrated this:

*“I told my aunt that I went to the Friendship Bench, then she said all right, now that you have done that, things are well because you can find someone there whom you can offload your burden onto.” (Participant\_01\_Non-engaged)*

Some 3 participants’ caregivers or parents believed their children would change and that coming to the Friendship Bench would be a learning process. They perceived the services provided by the Friendship Bench as a way to facilitate a positive change in attitudes of adolescents and likewise behaviour. The hope was also that adolescents would work as a communication medium and impart whatever knowledge they had received to their families. As a result parents and caregivers were generally supportive of these adolescents coming for sessions.

*“...they said maybe you can change, perhaps go.” (Participant\_04\_Engaged)*

*“I told her, and she said it is good, you can go and learn and tell us what you learnt there.” (Participant\_08\_Non-engaged)*



Despite some families being supportive of adolescents' attendance of sessions, some were not. One participant's father blatantly denied that his daughter had depression and said she was too young, and thus he would not let her attend sessions. The participant was resilient however and found another way to get to the Friendship Bench despite her father's disapproval.

*"...my father actually wanted to stop me from coming, he was saying what kufungisisa problem does she have, she should not go there, so I ended up sneaking out then coming with my grandmother..." (Participant\_13\_Non-engaged)*

### **Community Factors**

Community factors involved the availability of the Friendship Bench, travel to the health clinic, LHW attributes and location of benches. Travel to the health clinic was multi-faceted and included the presence or absence of a nearby clinic, distance to the clinic, length of travel to the clinic and cost of travelling to the clinic.

The continuous availability of the Friendship Bench can be seen as an enabling factor, as the participants were all aware that the Friendship Bench was a place where they could continue coming to get help. The majority of participants knew about other additional places where they could get psychosocial support, such as Sister-to-Sister, Parirenyatwa Hospital and a clinic at Machipisa Shopping centre. One participant had sought additional support from Sister to Sister as indicated in the quote below:

*"There is a program called Sister-to-sister – they have helped me overcome some of the issues I was facing, the Friendship Bench also helped me". Participant\_01\_Non-engaged*

However, the lack of a nearby clinic was also a cause of concern as indicated below in the following quotes:

*“The clinic [in my area] has not been built yet. They want to build one but right now it has not yet been built.” (Participant\_11\_Non-engaged)*

*“In [my area] there is nothing.” (Participant\_06\_Non-engaged)*

For five participants who lived further from the clinic, distance was a barrier to retention. For the seven participants who lived close to the clinic, proximity to the clinic was a facilitator to retention. One participant explained why it was easy to come back:

*“I found it easy because it is near and not very far off to me.” (Participant\_09\_Non-engaged)*

One participant who came to the clinic on foot and walked for two hours spoke about the need to have a clinic nearer, which would result in not having to walk too far. Alternatively, she suggested having a Friendship Bench nearby so that she does not have to walk too much. However, most participants who indicated distance as a barrier used public taxis to come to the clinic. One participant in particular spoke about having to travel for as long as two and a half hours with public taxis to come to the clinic as she lived very far off and there was no clinic near to where she lived:

*“I can say from home to the roundabout takes me about an hour and 30 minutes, for me then to get the combi [taxi] some combis [taxis] go around for a while, some delay to get people so it can take me about 2 hours when dropping off at Machipisa – then walking from Machipisa to come here maybe about 30 minutes.” (Participant\_06\_Non-engaged)*

For those participants that had to travel long distances using combis, this was a challenge as they had to factor in transport costs to get to the clinic. One participant from an area in Harare was temporarily staying in another area of Harare about 20 km from his home with his aunt. He failed to come for sessions during that period as he did not have transport money to travel across town.

*"I would not get transport money, as a person who is not going to work."  
(Participant\_04\_Engaged)*

Adolescents are often reliant on parents or caregivers and not much value is placed on transport funds for adolescents who are at home. Contrary to other parents who supported adolescents, some were not so supportive as reflected in the quote.

'LHW attributes' or quality of care was a frequently mentioned facilitator to retention by the majority of participants, despite also being reported as a barrier to retention for some participants. Participants reflected on having felt understood, there being the assurance of confidentiality, feeling 'free and relieved' while talking to the LHW, and the LHW speaking nicely and not being harsh.

*"When I was sitting talking to the LHW, I felt free and relieved talking to her, and I told her everything that had happened in my life." (Participant\_01\_Non-engaged)*

*"...the grandmother I spoke to explained that no one would find out...I shared with her, and I was like I felt free." (Participant\_10\_Non-engaged)*

*"...she really understood my problems; she's not the type of person with a temper who then asks you what you want them to do with your problems." (Participant\_11\_Non-engaged)*

The LHWs were also described as caring, comforting and motherly. On how the LHWs' conduct was helpful one participant said:

*"What the LHW spoke with me about really helped me, if you are getting help and you realise you are getting help you get the energy to keep coming back and keep coming back." (Participant\_03\_Engaged)*

As a suggestion, two male participants mentioned having younger LHWs may be helpful, and also if they were of the same gender (male). The justification was that younger people attract younger people, and if the LHW is of the same sex, it would be easier to connect. The Friendship Bench in Harare is comprised of elderly grandmothers who are on average 60 years old. Below are the two males' perspectives:

*"...we can have males, yah like younger males who understand that we are still young and they know the situations young males encounter. ...the LHWs will be doing adult things, so that is when you see we need young people who know the things." (Participant\_05\_Non-engaged)*

*"...like an elderly man I can tell him because we are of the same sex so we can connect in a way." (Participant\_02\_Non-engaged)*

Two participants from one clinic mentioned the location of the benches in the clinic as an issue. According to both participants, the Friendship Benches at this clinic are located in a central, very public place with disturbances, which makes it difficult for one to open up, cry and be free. Below is one of the clients' narration of this:

*“The benches are too close to the road; we are shy to be seen by people talking to the grandmothers. You need a private place so that when I want to cry, I will cry until I am relieved – yah because young children like us we do not want to be seen. You see like here at [this clinic] the benches are near to the road people will just be passing by looking at us – and you know what they disturb.” (Participant\_08\_Non-engaged)*

This participant suggested a more suitable location for the bench which was behind the buildings where there were no disturbances. This is described below:

*“They need to relocate their benches – somewhere maybe behind the buildings, yah where we can talk without disturbances...Just seeing bystanders, it disturbs. Maybe I’ll be looking at them and I now don’t concentrate on what you are talking to me about or what you are counselling to me.” (Participant\_08\_Non-engaged)*

The second participant suggested putting a shed which he said would make things better:

*“...if they could put a shed here it is better not for it to be too open like this.”  
(Participant\_10\_Non-engaged)*

The study revealed some important predisposing, need and enabling factors which have an implication on adolescents’ engagement within the Friendship Bench. However other factors such as evaluated need and demographic factors were not raised by participants.

# Chapter 5: Discussion

This chapter will focus on interpreting and describing the significance of the study's findings within the context of existing literature, discussing the relevance of Andersen's framework to this study and examining the other areas of study. This chapter will also report on the limitations of the study and provide recommendations to improve retention of adolescents into the Friendship Bench.

This study sought to improve the quality of the mental health service provided by the Friendship Bench for adolescents through investigating the barriers and facilitators affecting this age group. What is clear from the findings is that the barriers were significant, as seven out of 12 of the participants did not return for follow up sessions. Whilst three returned for one more follow up session, the remaining two participants returned for two or more sessions.

## 5.1 Barriers and facilitators to retention

In general, all participants reported understanding the need for counselling to address their symptoms. However, this alone was not enough to determine whether they returned for counselling, as other predisposing and enabling factors seemed to come into play. Predisposing factors included mental health beliefs while enabling factors included personal factors, family factors and community factors. Need factors were comprised of perceived need.

### **Predisposing factors**

Most participants seemed to not have any knowledge on common mental disorders or the Friendship Bench prior to coming to their first session. Their peers also seemed to lack any knowledge on depression, and as a result, participants felt the need not to disclose attendance of the Friendship Bench. Reasons for lack of disclosure seemed to be centred mostly around fear of stigma. Stigma is one of the major barriers to care as is reported in

literature, especially in LMICs and among vulnerable populations (Thornicroft, Alem et al. 2010). It is often the result of negative health beliefs, for example, little or no knowledge surrounding mental conditions and where to get help (Andrade et al., 2014).

Increasing knowledge and awareness of common mental disorders can help decrease stigma and also increase help seeking behaviour (Gulliver, Griffiths et al. 2010). Similar findings have been discovered in disclosure of HIV status. For example, stigma was a result of a lack of knowledge on HIV and a reduction in stigma and improvement in societal attitudes occurred after education on HIV (Chao, Gow et al. 2010). The phenomena of self-stigma is also common in high income countries where fear of discrimination restrains people from disclosing their mental condition (Wheat, Brohan et al. 2010).

After receiving services, however, adolescents indicated increased levels of literacy regarding depression, its causes and its effects. This was related to having a connection to their symptoms as they reflected on how the symptoms they had experienced resonated with those brought up by the LHWs. In this study, this knowledge did not appear to be a strong motivator for participants to continue seeking help at the Friendship Bench or other services. Contrary to this, literature suggests that young people are more likely to seek help if they recognize they have the knowledge that they have a mental health problem. Mental health literacy or knowledge in young people and their supporters, (e.g., friends and family), has been found to facilitate service use in other studies (Kelly, Jorm et al. 2007).

This begs the question of whether the content of the knowledge provided during the first session of the Friendship Bench was enough for adolescents to come back for more sessions, or whether other barriers overwhelmed the initial desire to continue getting help from the Friendship Bench. Indeed, adolescents who did not return reported that they felt they had received sufficient help during the first session and thus did not feel they needed a second session.

## **Need factors**

The participants that attended follow up sessions had stronger facilitators that were not related to their knowledge of depression. For example, one of the two participants that returned for two more follow up sessions had severe symptoms and quite a number of issues that acted as push factors to continue seeking help at the Friendship Bench. Literature suggests that the greater the symptom severity or experience with depressive symptoms the higher the chance of clients coming back for more sessions (Merikangas, He et al. 2011). In a face-to-face survey of US adolescents aged 13-18 with behaviour disorders, attention disorders and eating disorders, severe impairment and disorder severity were linked to retention (Merikangas, He et al. 2011).

In the present study, all participants had experienced at least one or several symptoms of CMDs before attending counselling. The symptoms the LHWs brought up also resonated with how participants were feeling at the time of coming to the Friendship Bench. However, even after the participants discovered that the symptoms they had been experiencing were as a result of depression, this still led to little or no further session attendance. A study involving rural veterans aged 18 and above from four states in the US suggested that improvements in symptoms encouraged participants to remain engaged in mental health services (Fischer, McSweeney et al. 2016).

The results from this current study suggest otherwise, as adolescents reported stopping coming to the Friendship Bench when they felt better. Participants' attendance of one to two sessions could point to adolescent health service use behaviour (need to experiment) as well as temperament, namely their ability to control impulses and self-regulate (Silverman, 2013). Additionally, adolescent risk-taking or experimentation is common in adolescence and is associated with the developmental stage of independence and autonomy (Silverman, 2013, Clark, Donnellan, Robins, & Conger, 2015).



The Friendship Bench intervention is usually comprised of six sessions (Chibanda, Mesu et al. 2011). Further, results from the RCT indicate that for the intervention to be effective among adults, one should have attended at least three individual sessions (Chibanda, Mesu et al. 2011). And yet some participants in the present study felt that just one or two sessions were sufficient to address their needs as mentioned above. This result demonstrates two other things. First, some of the participants may not have had symptoms as severe as they initially presented with transient symptoms. There is no published research that has looked at the psychometric properties of the SSQ-14 in this age group. Therefore, the positive and negative predictive values which inform on the true positive (cases) and negative (non-cases) clinically are not known with the SSQ-14 in this age group. Secondly, the participant may have sought help somewhere else as LHWs are trained to refer patients requiring specialised support or care. For instance, one participant did not come back for additional sessions at the Friendship Bench because she had sought help from a community service.

Sister to Sister is a religious community organization which provides empowerment for women through education to provide care for those living with HIV/AIDS (Sister-to-Sister, 2017). In addition to this, Sister to Sister has a support group component which provides spiritual and psychosocial support for the women (Sister-to-Sister, 2017). The participant, aged 17 at the time, sought help there because her younger brother is HIV positive and she is the child's primary caregiver. In this case, both the knowledge and severity of the problem acted as facilitators even if help was not sought at the Friendship Bench. Future research should therefore focus on whether one or two sessions are enough to indicate clinical improvement among adolescents attending the Friendship Bench.

It is important to note that during the course of recruitment, four participants who had scored below 9 on the SSQ 14 but who had shown signs of distress (such as crying) had been referred to the Friendship Bench all the same and had attended sessions. Consequently, these participants were recruited for this study as they met inclusion criteria and all were assigned to the non-engaged group. The low SSQ-14 score may have been a reason for poor retention – as the adolescents may have simply needed psychosocial support and not the intervention.

This is evidenced by some adolescents who mentioned self-help techniques such as playing sport as a way of reducing depression. Young people often use self-help techniques and complementary treatments as ways to deal with mental health problems (Rickwood 2012). It is worth incorporating use of self-help techniques and complementary treatments into the development of adolescent psychosocial intervention packages.

### **Enabling factors**

Family support was identified as influencing Friendship Bench service use. All participants were living with either a spouse, a parent, both parents, employers, extended family and in-laws. For those adolescents living with family, support and encouragement were imperative for them to continue to access the Friendship Bench. However, this study's findings showed that family support acted as both a facilitator and a barrier. As evidently shown by one participant whose father denied her attendance whilst her grandmother was in full support of her attendance. This shows that it might be important for young people to have someone to support them through session attendance. This is further discussed below.

The importance of support from family members in retention to care is supported by the benefits seen when family members are purposefully asked to engage in the depressed individual's treatment. A method of family involvement is used in the Zvandiri model, a local community-based project in Zimbabwe which is centred on improving adherence, retention in care and psychosocial outcomes specifically among HIV positive adolescents (Mavhu, Berwick et al. 2013, Mavhu, Willis et al. 2017).

Part of the intervention's focus is on adolescent behaviour change using a family centred approach (Mavhu, Berwick et al. 2013, Mavhu, Willis et al. 2017), by providing caregiver workshops and trainings as part of the model (Mavhu, Willis et al. 2017). The Zvandiri model indicates how instrumental it is for therapy targeted at young people to include a component of family therapy. Qualitative findings from a study of adolescents aged 15-19 diagnosed with

major depressive disorder and recruited from the Zvandiri program indicated elements of family support as helpful in therapy (Willis, Mavhu et al. 2018).

Personal factors, such as other reasons to come to the clinic, were a strong facilitator for continued service use. Other reasons for coming included accompanying someone to the clinic, bringing their babies or others' babies to the clinic and coming to collect medication for a family member. The fact that the Friendship Bench service is provided within clinics means however, that sessions can be scheduled to coincide with other health visits at the clinic, to help facilitate retention. Conflicting priorities however was a barrier to care, and it generally influences access to all types of health care and across all age groups. Adolescents who were committed to school or work found it difficult to make time to come to the Friendship Bench due to their school and work schedules coinciding with Friendship Bench session. Australian participants attending a recovery program stated competing commitments (childcare and employment) among some of the reasons for not attending recovery classes (Dunn, Chow et al. 2016).

Distance to the clinic also influenced retention to care as well as having no access to personal funds. Having no access to own funds meant having to ask someone to help with transport. There are over 50 City Health Department clinics in Harare, the Friendship Bench is available at 42 of these. For some participants, the clinic was near and within walking distance, but for participants who lived in geographically inaccessible areas and far from any clinic, they had to opt for public transport to access the clinic. The absence of a nearby clinic therefore meant participants had to factor in transport costs and time to commute thus making the process of travelling to the clinic a bit too complicated.

Other studies looking at proximity and travel as a barrier or facilitator have found that rurality and transport had a bearing on service attendance (Pullmann, VanHooser et al. 2010). Commuting was often time consuming and costly on those adolescents who had to travel to access a Friendship Bench. In the context of poverty, the costs of travelling are often

unaffordable, which subsequently leads to treatment drop-out (Pullmann, VanHooser et al. 2010). This brings into question whether reimbursing transport to adolescents who come to the Friendship Bench will help improve retention. This may not be a legitimate idea however because of issues to do with sustainability.

Characteristics of the FB intervention such as LHW attributes and location of Friendship Benches were also reported as having an impact on retention. Participants reported on several characteristics they found favourable among the LHWs. Within this study participants mentioned feeling understood, feeling free and relieved during the session, the LHW speaking nicely and not being harsh as well as the assurance of confidentiality. Similarly, findings from a study with 12-17-year-old Australian males also indicated that maintaining confidentiality was an important facilitator (Rice, Telford et al. 2018). Other studies also identified staff attitudes as influencing drop-out or retention. For American adolescents aged 13-17, having respectful staff decreased drop-out whilst negative staff attitudes led to treatment drop-out (Oruche, Downs et al. 2014).

LHWs in the present study were also described as motherly, caring and comforting. This support a previous study conducted among rural veterans, who echoed the need to feel cared for as a facilitator to engagement (Fischer, McSweeney et al. 2016). On the other hand, however, some male participants indicated preference for younger and male LHWs in the present study, as they said these would be easier to interact with. One study involving young males aged 12-17 corroborates this, as young males found that male gender of the service provider was key to service use (Rice, Telford et al. 2018). Overall a health service provider who was easy to get along with was beneficial (Kozloff, Cheung et al. 2013). Despite other factors being reported in other studies, such as staff members who are respectful and who communicate timely, and who can be trusted, these did not emerge in the present study.

Another important finding was the location of Friendship Benches at one polyclinic. The benches were located in a public and central place according to two participants. According

to them, this meant minimal privacy and a lot of disturbances which made it difficult for them to open up or cry. The benches at the polyclinic were located there as the LHWs thought it was a more convenient and central location to invite clients. The concept of the Friendship benches however is contingent on location in a discrete area (Chibanda, Bowers et al. 2015). The fact that the benches were more public is even more problematic for adolescents who may not want others to know they are attending the Friendship Bench, as reported by two participants.

The findings are similar to a Saudi Arabian study focusing on the health providers' perspective on what the barriers to patient counselling are (Albekairy 2014). Lack of privacy partly due to interruptions by other staff was mentioned as a barrier, and as a result one of the recommendations was that a proper setting for counselling be provided (Albekairy 2014). Possible locations of benches can be in schools and in public parks. The benefits of using schools and park benches is that this eliminates the stigma associated with being seen in a health care centre. Additionally, having a bench within a school set-up makes it easily accessible to school-going adolescents. For example, in Australia schools have been found to be an ideal and opportunistic setting to reach adolescents through counselling (Australian Bureau of Statistics 2005). However, school benches are only effective provided the school programme is not packed with activities allowing time to sit at the bench (Langley, 2010). Park benches, on the other hand, have the disadvantage of being public thus there is very little privacy during sessions. This has been found to be so in HIV programs in Cameroon which have had to make use of counselling in public (Ngangue, 2017).

## 5.2 Relevance of Andersen's framework to this study

The framework helped to frame the research questions, guide the review of literature, design the interview guide, and interpret the results. Given the qualitative nature of the present study, some factors within the framework could not be analysed for their impact, for example, demographic characteristics such as age, race and gender; waiting times and genetic factors. Yet literature points to factors such as age, gender, race (Wang, Aguilar-Gaxiola et al. 2007) and waiting times (Brown, Rice et al. 2016) as having an effect on mental health service use.

Future research employing quantitative methods should examine genetic and demographic factors as other studies have found that these factors are linked to poor retention (Bruwer, Sorsdahl et al. 2011, Siegel, Wanderling et al. 2013, de Haan, Boon et al. 2012).

The framework was very broad and encompassed a lot of factors. As such, no other factors that did not fit into the model emerged. Despite the semi-structured interview guide which allowed some level of flexibility in the questions, it is possible that the use of the framework itself may have limited the interview questions to specific barriers and facilitators, thus preventing other factors to be identified.

Alternative models may have provided a different insight into the barriers and facilitators to retention among adolescents, such as Rosenstock's health belief model (HBM) (Rosenstock, 1974), Suchman's seeking care model (Geertsen, Klauber, Rindflesh, Kane, & Gray, 1975) and Mechanic's illness behaviour model (Mechanic, 1962). Mechanic's model specifically could have identified some factors relating to social and cultural constructs as influencing health service use – factors which were difficult to investigate with the current model used. However, Andersen's framework has been used widely to explain health service use in various health care departments, particularly in low-income settings.

### 5.3 Limitations

Some limitations were identified. First, the study was limited to just five clinics in Harare. Although the clinics varied in geographical location, barriers and facilitators identified across clinics were somewhat similar – if more clinics from different areas had been included in the study different factors may have been identified. Despite each setting's uniqueness, this study's findings generally concur with other previous studies' findings and can thus be generalized to other clinic and community settings in Zimbabwe.

Also, despite aiming to balance the number of adolescents recruited by gender only four males were recruited and interviewed. This could be an indication of depression and anxiety

prevalence rates differing across gender in Zimbabwe, as depression and anxiety are generally more common among females than males (World Health Organization 2017). Because the study focused on adolescents aged 15-17, the results cannot be generalized to other age groups, such as younger adolescents or young adults. Further research is needed to investigate barriers and facilitators among other age groups as this may bring up different barriers and facilitators, that is, work will likely not be a barrier to retention among younger adolescents, but school will.

The sample was homogenous, as participants were suffering from common mental disorders but no other chronic conditions. Thus, the findings are not generalizable to the adolescent population in Zimbabwe or to other adolescents that attend the clinic such as HIV positive adolescents or adolescents with high blood pressure or substance use disorder. Another limitation of this study was that it focused only on the perspective of the adolescent and did not focus on the perspectives of service providers or caregivers. Interviewing service providers may have provided some insight into the evaluated need factor mentioned in Andersen's framework. Caregivers may have also provided more family related barriers from their perspective. Additional perspectives would have strengthened the study's findings.

Sampling and recruitment seemed to be this study's main limitation. First, due to time and budget constraints, as well as difficulty in finding participants, only twelve participants were interviewed and included in the study, from which only two were from the engaged group, which is a small sample size and limits our understanding to what might or might not work. Three potential participants were lost as they suggested they could be interviewed over the phone but for ethical reasons, the study did not allow for phone interviews. The unbalanced sample between the engaged and non-engaged group may not be such a problem, however, given that both engaged and non-engaged participants identified barriers and facilitators to retention.

Four non-engaged participants who were recruited for this study were referred to the Friendship Bench intervention by LHWs directly, despite scoring below 9 on the SSQ-14. The participants' initial low levels of depressive symptoms may have had an impact on their willingness to return for further sessions. For this reason, restricting the study to only those clients who were referred to the Friendship Bench intervention in the conventional way (i.e. based on their screening score), may have been a more appropriate sampling strategy. As described above, the sample may be further biased given that the SSQ-14 has not been validated among adolescents, so it not possible to tell whether the SSQ-14 is sensitive enough to detect depression among this age group.

#### 5.4 Implications for practice and research

The findings from this study have implications for the existing Friendship Bench program within clinics, the proposed 'Youth Friendship Bench' program, as well as future research. The Friendship Bench program caters for all age groups and the service is available within clinics. The proposed Youth Friendship Bench program will focus on providing the service for adolescents in more flexible spaces within the community, e.g., in parks, churches, market places and other convenient locations. The findings from this study will be instrumental in developing a more user-friendly Youth Friendship Bench. The findings are also useful for LHWs working with adolescents within more than 60 clinics where the Friendship Bench has been scaled up in Zimbabwe. Some key recommendations are provided below.

The introduction of younger LHWs and where possible a few male LHWs as well will aid in facilitating young people's retention. Introduction of male LHWs will allow for gender matching which can sometimes make building rapport between a client and service provider easier. Provision should also be made for locating benches in private spaces within the clinic set up to allow for more privacy during sessions. Private spaces also have the added benefit of being free of interruptions. Locating Friendship Benches in schools and other adolescent friendly spaces within the communities may also prove helpful for facilitating access. Overall, psychosocial interventions targeted at young people should aim to have both male and female counsellors of varying age groups in order to cater to young people's varying needs.



Provision of transport money for adolescents who come to the Friendship Bench or attend other psychosocial interventions should be looked into. Introducing mobile Friendship benches or a mobile counselling service to reach adolescents who live far from the clinics may be another alternative. Another option would be to use technology as a counselling channel versus face-to-face counselling as this would eliminate the need to come to the clinic. Indeed, both cognitive behavioural therapy and psychoeducation delivered over the internet were found to be effective for reducing symptoms of depression among Australian participants aged 18+ (Christensen, Griffiths et al. 2004). Introduction of self-help techniques as part of the intervention for those adolescents who have depressive symptoms but not depression is also another alternative. Self-help techniques can also be introduced during single stand-alone sessions designed specifically for adolescents with the knowledge that adolescents may not come back.

It is essential that psychoeducation be provided in schools, churches and other central places within the community to reduce stigma. In addition to this the distribution of information, education & communication materials at these points to educate people about CMDs and reduce stigma. Further research is needed, such as interviewing various LHW groups, which may also provide more information on barriers and facilitators to retention. Further, the involvement of parents or guardians in adolescent psychosocial support intervention design is also critical as the attendance of young people is very much contingent on family support. Interventions often focus on treatment, however interventions to improve mental health literacy in adolescents and families can also be designed. These interventions or campaigns can help with recognizing CMDs, reducing stigma, raising awareness and reduction in perceived barriers.

It is thus important to raise awareness of depression and the Friendship Bench among family members and friends of adolescents as they have a strong influence on access and retention to care. Adolescents are particularly dependant and easily influenced.

## Chapter 6: Conclusion

This study sought to explore the perceived barriers and facilitators that adolescents with common mental disorders experience in retention to a psychosocial Intervention. The findings in this study reflected that retention of adolescents in the Friendship Bench was low as the majority of participants within this study did not return for follow up sessions. Indeed, many young people drop out of services despite the availability of effective treatments (Michael and Crowley 2002, Merikangas, He et al. 2011).

The study identified key barriers and facilitators to retention in the Friendship Bench among adolescents. Some factors doubled up as both a barrier and a facilitator depending on the context. Barriers and facilitators included LHW attributes, distance to the clinic, family and other support systems, perceived need, mental health beliefs or knowledge, stigma, the location of benches, and personal factors such as school commitments and other reasons to come to the clinic.

Some of the recommendations from the study's findings include offering safe spaces for adolescents to get care, for example in schools or using internet based platforms; provision of transport or mobile Friendship Benches to overcome distance and travel costs; adapting the intervention for adolescents through creating tailor-made sessions for adolescents (which could include a self-help component) and providing psycho-education and awareness campaigns or interventions for families and communities.

The findings from this study contribute towards improving access as well as retention among adolescents coming to the Friendship Bench, which should in turn improve mental health outcomes of adolescents suffering from CMDs in Zimbabwe. The findings are also relevant to those health providers working with adolescent populations as well as future research involving adolescents within the Friendship Bench and other psychosocial interventions.

Additionally, the results of this study will help provide information that will assist in the formative work of the 'Youth Friendship Bench' package.

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# Appendix A: Parental Consent

## ENGLISH VERSION

### PARENTAL CONSENT FORM

**PROJECT TITLE:** *Barriers and facilitators of retention to a psychosocial intervention among adolescents with common mental disorders in Harare: A Qualitative Study.*

**Principal Investigator:** Ms. Emily Baron

**Phone Number(s):** +27 216501095

#### INTRODUCTION

We are asking your child to take part in a study. We give you this form so that you may read about the purpose, risks, procedures and benefits of your child taking part in this research study. The main goal of research studies is to gain knowledge that may help future patients. You have the right to refuse to allow your child to take part or agree for your child to take part now and change your mind later. Whatever you decide, it will not affect your child's regular care.

#### PURPOSE

We are asking you to allow your child to take part in a research study involving adolescents who screened positive for common mental disorders. The purpose of the study is to explore the barriers and facilitators that adolescents with common mental disorders (CMDs) come across in accessing the Friendship Bench intervention. The Friendship Bench is a program within the clinics that focuses on those with depression and anxiety. We selected your child as a possible participant in this study because he / she used the Friendship Bench. The study will recruit a total of 20 participants all from Harare, Zimbabwe.

#### PROCEDURES AND DURATION

If you decide to allow your child to participate, your child will be interviewed by a researcher for approximately 1 hour. We will set-up an appointment with your child so that they can be

interviewed. Your child will be required to present proof of guardianship if available. Your child will be interviewed on their own. We will audio record the interview. During the interview we will discuss your child's experience in accessing the Friendship Bench as well as with the Lay Health Workers (LHWs) the Friendship Bench. The aim will be to find out whether there were any factors that inhibited or facilitated your child's use of the service, and how. We will delete all recordings upon completion of the research study.

### **RISKS AND DISCOMFORTS**

There is minimal risk and discomfort anticipated in your child taking part in this study. However if your child does feel that a question is sensitive in nature and may cause discomfort, he / she is does not have to answer. Your child may also choose to stop the interview whenever he / she feels like it. However if any discomfort is caused your child will be referred back to the Friendship Bench for counselling.

### **BENEFITS AND/OR COMPENSATION**

The study will provide more knowledge to LHWs on how to work with adolescents presenting with symptoms of CMDs. The study will also help improve adolescents' access to mental health services as well as adolescent mental health outcome. We cannot and do not guarantee or promise that your child will receive any direct benefits from this study. Transport of \$3 will also be provided when your child reports to the clinic to collect consent and assent forms. After the interview your child will receive \$3 to cover transport costs as well as a snack and something to drink.

### **CONFIDENTIALITY**

If you indicate your willingness for your child to participate in this study by signing this document, only the team directly involved in the research will have access to your child's file. Your child will be assigned a patient identification number which will be used to identify your child and protect their identity. Your child's name or contact details will only be used for the purpose of contacting you. The results of the study will be furnished to the University of Cape Town as a submission requirement for fulfilment of the researcher's Master's program, the City of Harare as well as to the Friendship Bench. The results will also be published in a journal.

Any information that is obtained in connection with this study that can be identified with you or your child will remain confidential and will be disclosed only with your permission. Under some circumstances, the Medical Research Council of Zimbabwe (MRCZ) may need to review patient records for compliance audits. Participants will have the option to receive the study results through email or registered mail.

#### **ADDITIONAL COSTS**

No extra costs will be incurred due to taking part in the study.

#### **VOLUNTARY PARTICIPATION**

Your child's participation in this study is voluntary. If you decide not to allow your child to participate in this study, your decision will not affect your child's future relations with the Friendship Bench or the clinic. If you decide to allow your child to participate, you and your child are free to withdraw your consent and assent and discontinue participation at any time without penalty.

#### **WHO DO I SPEAK TO IF I HAVE ANY QUESTIONS ABOUT THE STUDY?**

For questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your child's rights as a research participant or research-related injuries; or if you feel that your child has been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the MRCZ on telephone (04)791792 or (04)791193 and cellphone number 0784956 128. The offices are located at Corner J. Tongogara and Mazowe Avenue. The UCT's Faculty of Health Sciences Human Research Ethics Committee can also be contacted on +27 21 406 6338 in case you have any ethical concerns or questions about your rights or welfare as a participant on this research study.

**PLEASE NOTE: YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM.**

#### **SIGNATURE PAGE**

***Barriers and facilitators of retention to a psychosocial intervention among adolescents  
with common mental disorders in Harare: A Qualitative Study.***

**Version 1.6 / 28 September 2017**

**OFFER TO ANSWER QUESTIONS**

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

**AUTHORIZATION**

You are making a decision whether or not to allow your child to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

_____	_____
Name of Parent or Guardian (Please Print)	Date

_____	_____
Signature of Parent or Guardian	Time

\_\_\_\_\_  
Relationship to the Participant

_____	_____	_____
Name of Investigator	Signature	Date

**Statement of Consent for your Child to be Audio taped.**

I understand that audio recordings will be done during the study. *(Please choose YES or NO by inserting your initials in the relevant box).*



- I agree to my child **being audio recorded**

**Yes**

☐

**No**

☐

\_\_\_\_\_  
Name of Parent or Guardian (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Appendix B: Informed Assent

## ENGLISH VERSION

### INFORMED ASSENT FORM

**PROJECT TITLE:** *Barriers and facilitators of retention to a psychosocial intervention among adolescents with common mental disorders in Harare: A Qualitative Study.*

**Principal Investigator:** Ms. Emily Baron

**Phone Number(s):** +27 216501095

### INTRODUCTION

You are being invited to take part in a study. We give you this form so that you may read about the purpose, risks, procedures and benefits of taking part in this research study. The main goal of research studies is to gain knowledge that may help future patients. You have the right to refuse to take part, or agree to take part now and change your mind later. Whatever you decide, it will not affect your regular care.

### PURPOSE

You are being asked to take part in a research study involving adolescents who screened positive for common mental disorders. The purpose of the study is to explore the barriers and facilitators that adolescents with common mental disorders (CMDs) come across in accessing the Friendship Bench intervention. You were selected as a possible participant in this study because you used the Friendship Bench. The study will recruit a total of 20 participants all from Harare, Zimbabwe.

### PROCEDURES AND DURATION

If you decide to participate, you will be interviewed by a researcher for approximately 1 hour. An appointment will be made with you so that you can be interviewed at the clinic. You will be required to present proof of guardianship if available. You will be interviewed on your own. The interview will be audio recorded. During the interview we will discuss your

experience in accessing the Friendship Bench as well as with the Lay Health Workers (LHWs) at the Friendship Bench. The aim will be to find out whether there were any factors that inhibited or facilitated your use of the service, and how. All recordings will be deleted upon completion of the research study.

### **RISKS AND DISCOMFORTS**

There is minimal risk and discomfort anticipated in taking part in this study. However if you do feel that a question is sensitive in nature and may cause discomfort, you do not have to answer. You may also choose to stop the interview whenever you feel like it. However if any discomfort is caused you will be referred back to the Friendship Bench for counselling.

### **BENEFITS AND/OR COMPENSATION**

The study will provide more knowledge to LHWs on how to work with adolescents presenting with symptoms of CMDs. The study will also help improve adolescents' access to mental health services as well as adolescent mental health outcomes. We cannot and do not guarantee or promise that you will receive any direct benefits from this study. Transport of \$3 will be provided when adolescents report to the clinic to collect consent and assent forms. After the interview you will also receive \$3 to cover transport costs as well as a snack and something to drink.

### **CONFIDENTIALITY**

If you indicate your willingness to participate in this study by signing this document, only the team directly involved in the research will have access to your file. You will be assigned a patient identification number which will be used to identify you. Your name or contact details will only be used for the purpose of contacting you. The results of the study will be provided to the University of Cape Town as a submission requirement for fulfilment of the Master's program, as well as to the Friendship Bench. The results will also be published in a journal.

Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission. Under some circumstances, the Medical Research Council of Zimbabwe (MRCZ) may need to review

patient records for compliance audits. Participants will have the option to receive the study results through email or registered mail.

#### **ADDITIONAL COSTS**

No extra costs will be incurred due to taking part in the study.

#### **VOLUNTARY PARTICIPATION**

Your participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the Friendship Bench or the clinic. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty.

#### **PLEASE NOTE: YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM.**

For questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the MRCZ on telephone (04)791792 or (04)791193 and cellphone number 0784956 128. The offices are located at Corner J. Tongogara and Mazowe Avenue. The UCT's Faculty of Health Sciences Human Research Ethics Committee can also be contacted on +27 21 406 6338 in case you have any ethical concerns or questions about your rights or welfare as a participant on this research study.

#### **SIGNATURE PAGE**

***Barriers and facilitators of retention to a psychosocial intervention among adolescents with common mental disorders in Harare: A Qualitative Study.***

**Version 1.6 / 28 September 2017**

#### **OFFER TO ANSWER QUESTIONS**

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

## AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

Name of Research Participant (Please Print)

---

Date \_\_\_\_\_

Signature

Name of Investigator

Signature

Date \_\_\_\_\_

**Statement of Consent to be Audio taped.**

I understand that audio recordings will be done during the study. *(Please choose YES or NO by inserting your initials in the relevant box)*

- I agree to **being audio recorded**

7

10

Name of Participant (Please Print)

Signature

Date \_\_\_\_\_

## Appendix C: Adult Consent

### ENGLISH VERSION

#### ADULT CONSENT FORM

**PROJECT TITLE:** *Barriers and facilitators of retention to a psychosocial intervention among adolescents with common mental disorders in Harare: A Qualitative Study.*

**Principal Investigator:** Ms. Emily Baron

**Phone Number(s):** +27 216501095

#### INTRODUCTION

You are being invited to take part in a study. We give you this form so that you may read about the purpose, risks, procedures and benefits of taking part in this research study. The main goal of research studies is to gain knowledge that may help future patients. You have the right to refuse to take part, or agree to take part now and change your mind later. Whatever you decide, it will not affect your regular care.

#### PURPOSE

You are being asked to take part in a research study involving adolescents who screened positive for common mental disorders. The purpose of the study is to explore the barriers and facilitators that adolescents with common mental disorders (CMDs) come across in accessing the Friendship Bench intervention. You were selected as a possible participant in this study because you used the Friendship Bench. The study will recruit a total of 20 participants all from Harare, Zimbabwe.

#### PROCEDURES AND DURATION

If you decide to participate, you will be interviewed by a researcher for approximately 30 minutes to 1 hour. An appointment will be made with you so that you can be interviewed at the clinic. You will be interviewed on your own. The interview will be audio recorded. During the interview we will discuss your experience in accessing the Friendship Bench as well as

with the Lay Health Workers (LHWs) at the Friendship Bench. The aim will be to find out whether there were any factors that inhibited or facilitated your use of the service, and how. All recordings will be deleted upon completion of the research study.

### **RISKS AND DISCOMFORTS**

There is minimal risk and discomfort anticipated in taking part in this study. However if you do feel that a question is sensitive in nature and may cause discomfort, you do not have to answer. You may also choose to stop the interview whenever you feel like it. However if any discomfort is caused you will be referred back to the Friendship Bench for counselling.

### **BENEFITS AND/OR COMPENSATION**

The study will provide more knowledge to LHWs on how to work with adolescents presenting with symptoms of CMDs. The study will also help improve adolescents' access to mental health services as well as adolescent mental health outcomes. We cannot and do not guarantee or promise that you will receive any direct benefits from this study. Transport of \$3 will be provided when adolescents report to the clinic to collect consent and assent forms. After the interview you will also receive \$3 to cover transport costs as well as a snack and something to drink.

### **CONFIDENTIALITY**

If you indicate your willingness to participate in this study by signing this document, only the team directly involved in the research will have access to your file. You will be assigned a patient identification number which will be used to identify you. Your name or contact details will only be used for the purpose of contacting you. The results of the study will be provided to the University of Cape Town as a submission requirement for fulfilment of the Master's program, as well as to the Friendship Bench. The results will also be published in a journal.

Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission. Under some circumstances, the Medical Research Council of Zimbabwe (MRCZ) may need to review patient records for compliance audits. Participants will have the option to receive the study results through email or registered mail.

### **ADDITIONAL COSTS**

No extra costs will be incurred due to taking part in the study.

### **VOLUNTARY PARTICIPATION**

Your participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the Friendship Bench or the clinic. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty.

### **PLEASE NOTE: YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM.**

For questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the MRCZ on telephone (04)791792 or (04)791193 and cellphone number 0784956 128. The offices are located at Corner J. Tongogara and Mazowe Avenue. The UCT's Faculty of Health Sciences Human Research Ethics Committee can also be contacted on +27 21 406 6338 in case you have any ethical concerns or questions about your rights or welfare as a participant on this research study.

### **SIGNATURE PAGE**

***Barriers and facilitators of retention to a psychosocial intervention among adolescents with common mental disorders in Harare: A Qualitative Study.***

**Version 1 / 6 February 2018**

### **OFFER TO ANSWER QUESTIONS**

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.



## AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

Name of Research Participant (Please Print)

Date \_\_\_\_\_

Signature

Name of Investigator

Signature

Date \_\_\_\_\_

**Statement of Consent to be Audio taped.**

I understand that audio recordings will be done during the study. *(Please choose YES or NO by inserting your initials in the relevant box)*

- I agree to **being audio recorded**

**Yes**

11

**No**

11

Name of Participant (Please Print)

Signature

---

Date \_\_\_\_\_

## Appendix D: Qualitative Researcher's Confidentiality Agreement

**Title of Dissertation:** Barriers and facilitators of retention to a psychosocial intervention among adolescents with common mental disorders in Harare: A Qualitative Study.

I ..... agree to the following:

-To keep confidential all details pertaining to this research

☐

-To carry out the following duties as needed: interviews, transcriptions and translations

☐

-I will not make copies of any of the data or keep any record of them

☐

**Signature:** .....

**Date:** .....

## Appendix E: Interview Guide

**Topic:** Barriers and facilitators of retention to a psychosocial intervention among adolescents with common mental disorders in Harare: A Qualitative Study.

### Interview Guide for Adolescents:

Good morning/afternoon, my name is \_\_\_\_\_. I am a researcher and I will be interviewing you today. I hope to find out more about what difficulties you came across in coming to the Friendship Bench or what made it easier for you to continue coming, as well as your experience at the Friendship Bench. The interview will take about 1 hour. There is no right or wrong answer to the questions. If you do not understand a question, please tell me at any stage, and we can discuss what I mean. The information that you give will stay private and confidential. Before we start the interview I will ask you to provide filled in and signed copies of your consent and assent forms stating that you and your parent / guardian are agreeing for you to take part in this interview. In order to capture your thoughts I will be recording the interview.

#### 1. Socio-demographics:

- Age: 15 ☐          16 ☐          17 ☐
- Gender: Female ☐          Male ☐
- Ethnicity: \_\_\_\_\_

2. Can you tell me what your home is like and who you live with in your home?
3. Are you still in school? If yes, what Form?
4. What is / was your experience at school like?
5. Are you employed?

#### *If yes, prompt:*

- What work do you do?
- How many hours do you work a day and how many days a week?

6. How do you travel to the clinic? How long does it take you?
7. I would like to talk a bit about depression and anxiety. Do you know what depression or anxiety is?

[If No: Use symptoms (feeling sad, like crying, losing sleep, over-thinking, etc) of depression and anxiety in place of 'anxiety and depression' or kufungisisa for the rest of the interview].

***If yes, Prompt then proceed:***

- What is it?
  - How did you hear about it?
8. What things happen in life that cause depression and anxiety?
  9. How do you think that depression and anxiety can affect your life?
  10. Do you think depression/anxiety can be treated? If yes, how and by whom?
  11. What is the general belief among your family and friends about depression and anxiety?
  12. Does anyone in your family have depression or anxiety?  
***Prompt:*** If yes, what help did they get for it?
  13. Do you know if there are any services available that can help people who have depression or anxiety?  
***Prompt:*** Have you used any of these services? If yes, please explain why?

**Friendship bench:**

14. Now I would like to talk a bit about the Friendship bench. Can you explain what happened the day you were referred to see a LHW at the Friendship bench?
15. What do you think were the reasons you were referred to the Friendship Bench?
16. How often did you feel like that *[participant's response]*? (Depression/anxiety)
17. Once you had a session with the LHW, do you think it helped you?  
If yes, in what way did it help you?  
If not, why do you think it was not helpful?
18. What was it like talking to the LHW?

19. Do you think the assessment the LHW made of you was accurate? Please could you explain?

20. Are your family members and friends aware that you use or have used the FB?

**Prompts:**

- *If not aware* – why not?
- *If aware*, have your family or friends been positive or negative towards the Friendship Bench? – In what ways?
- How has the attitude of your family and friends influenced your use of the Friendship Bench and attending sessions?

21. Did you come back for a third session at the FB?

**If yes:**

- How many sessions did you have in total?
- Did you find it easy or hard to come back for more sessions?
- If easy – please explain why?
- If hard – please explain why?
- What made you stop coming, eventually?  
(*prompt*: for example, the way the LHW treated you, or your transport, waiting time, your family, your friends, your school?)

**If no:**

- Why do you think it is that you didn't come back?
- What things stopped you from coming back?  
(*prompt*: for example, the way the LHW treated you, or your transport, waiting time, your family, your friends, your school?)

22. If you could make it easier for people like you or your friends, to go to the counselling sessions at the FB, what would you change?

**Prompts:**

- What would you change about the LHWs?

- What would you change about the things that make it easier for you to physically get there yourself?
- What would you change about what your family thinks?

***We have come to the end of the interview. Thank you so much for your time. Do you have any questions for me? Or comments or thoughts about what we have discussed today?***

## Appendix F: City of Harare Approval Letter:



Director of Health Services

DR PROSPER CHONZI  
MBChB, MPH, MBA

### CITY OF HARARE

All correspondence to be addressed to the

DIRECTOR OF HEALTH SERVICES

3/7

Ref:-----

Your Ref:-----

#### DIRECTOR OF HEALTH SERVICES

Rowan Martin Building,  
Civic Centre,  
Pennefather Avenue,  
off Rotten Row,  
Harare, Zimbabwe.

P.O. Box 596  
Telephone: 753326  
753330/1/2  
Fax: (263-4) 752093

22 May 2017

Rhulani Beji-Chauke  
92 Prince Edward,  
Milton Park,  
Harare

Dear Madam

**RE: PERMISSION TO ACCESS FRIENDSHIP BENCH PATIENT FILES.**

I refer to the above.

Your request is hereby acknowledged. Permission is hereby granted for you to access Friendship Bench clinic data for your study titled: "An investigation into the barriers and facilitators that adolescents with common mental disorders (CMD) experience in adhering to the Friendship Bench Intervention in Harare. A qualitative study".

For further information please liaise with District Health Promotion Officers and Sisters in Charge in your proposed working areas. Please be reminded to send in copies of your research results for our records as well as for Health Research Database. You are also encouraged to submit electronic copies of your publication in peer reviewed journals that may emanate from this study.

For further guidance and assistance you may contact Mrs P. Chitando [Nursing Manager] or Mr I.P. Makwara [Principal Health Promotion Officer].

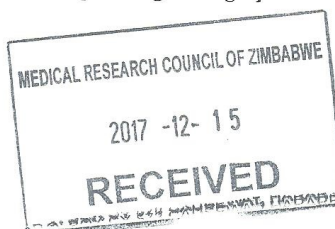
Looking forward to a fruitful working partnership

Yours faithfully,



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Dr. P. Chonzi  
**DIRECTOR OF HEALTH SERVICES**  
IPM/

Cc All DHEs  
All DHPOs  
All SIC



## Appendix G: HREC Approval

	<b>UNIVERSITY OF CAPE TOWN</b> <b>Faculty of Health Sciences</b> <b>Human Research Ethics Committee</b>	
		<b>Room E53-46 Old Main Building</b> <b>Groote Schuur Hospital</b> <b>Observatory 7925</b> <b>Telephone [021] 406 6492</b> <b>Email: <a href="mailto:sumayah.ariel@uct.ac.za">sumayah.ariel@uct.ac.za</a></b> <b>Website: <a href="http://www.health.uct.ac.za/fhs/research/humanethics/forms">www.health.uct.ac.za/fhs/research/humanethics/forms</a></b>

---

20 November 2017

**HREC REF:735/2017**

**Ms E Baron**  
Department of Psychiatry & Mental Health  
Centre for Public Mental Health  
Office 32, Building B, 46 Sawkins road  
Rondebosch

Dear Ms Baron

**PROJECT TITLE: BARRIERS AND FACILITATORS OF RETENTION TO A PSYCHOSOCIAL INTERVENTION AMONG ADOLESCENTS WITH COMMON MENTAL DISORDERS IN HARARE: A QUALITATIVE STUDY (Master's candidate-R Beji-Chauke)**

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee (HREC) for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

**Approval is granted for one year until the 30 November 2018.**

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.  
(Forms can be found on our website: [www.health.uct.ac.za/fhs/research/humanethics/forms](http://www.health.uct.ac.za/fhs/research/humanethics/forms))

***We acknowledge that the student: Ms R Beji-Chauke will also be involved in this study.***

**Please quote the HREC REF in all your correspondence.**

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate Institutional approval, where necessary, before the research may occur.

Yours sincerely

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**PROFESSOR M BLOCKMAN**  
**CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE**

Federal Wide Assurance Number: FWA00001637.

HREC 735/2017



## Appendix H: MRCZ Approval

Telephone: 791792/791193  
Telefax: (263) - 4 - 790715  
E-mail: [mrcz@mrcz.org.zw](mailto:mrcz@mrcz.org.zw)  
Website: <http://www.mrcz.org.zw>



Medical Research Council of Zimbabwe  
Josiah Tongogara / Mazoe Street  
P. O. Box CY 573  
Causeway  
Harare

### APPROVAL

REF: MRCZ/B/1404

18 December, 2017

Rhulani Beji-Chauke  
University of Cape Town  
Department of Psychiatry & Mental Health  
Rondebosch  
South Africa

#### RE:- BARRIERS AND FACILITATORS OF RETENTION TO A PSYCHOSOCIAL INTERVENTION AMONG ADOLESCENTS WITH COMMON MENTAL DISORDERS IN HARARE: A QUALITATIVE STUDY

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

- Study Proposal
- Informed Consent Forms (English and Shona)
- Data collection tools (English and Shona)

APPROVAL NUMBER

: MRCZ/B/1404

This number should be used on all correspondence, consent forms and documents as appropriate.

- |                           |                     |
|---------------------------|---------------------|
| • TYPE OF MEETING         | : Expedited         |
| • EFFECTIVE APPROVAL DATE | : 18 December, 2017 |
| • EXPIRATION DATE         | : 17 December, 2018 |

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on [mrcz@mrcz.org.zw](mailto:mrcz@mrcz.org.zw)

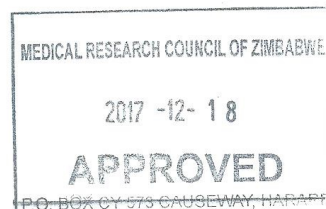
#### Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully



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MRCZ SECRETARIAT  
FOR CHAIRPERSON  
MEDICAL RESEARCH COUNCIL OF ZIMBABWE



PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

## Appendix I: HREC Amendment

	<b>HUMAN RESEARCH ETHICS COMMITTEE</b> 15 FEB 2018	<b>FACULTY OF HEALTH SCIENCES</b> Human Research Ethics Committee
<b>UNIVERSITY OF CAPE TOWN</b> <small>UNIVERSITEIT VAN KAPSTAD</small>	<b>HEALTH SCIENCES FACULTY</b> UNIVERSITY OF CAPE TOWN	
<b>Form FHS006: Protocol Amendment</b>		
<b>HREC office use only (FWA00001637; IRB00001938)</b>		
<input checked="" type="checkbox"/> Approved <input checked="" type="checkbox"/> Type of review: Expedited <input type="checkbox"/> Full committee		
This serves as notification that all changes and documentation described below are approved.		
Signature Chairperson of the HREC: <u>pp TBurgess</u> Date: <u>15/03/2018</u>		
Note: All <u>major</u> amendments must include a local PI Synopsis justifying the changes for the amendment. Please note that incomplete amendment submissions will not be reviewed.		
Comments from the HREC to the Principal Investigator:		
15/03/2018 Amendment approved. However, please provide evidence of local Zimbabwean Research Ethics approval + appropriate institutional approval for this study. The amendment approval is subject to appropriate Zimbabwean approvals being submitted to the HREC.		
Note: The approval of this protocol amendment does not grant annual approval. Please complete the FHS016 / FHS017 form for annual approval at least one month before study expiration.		
<b>Principal Investigator to complete the following:</b>		
<b>1. Protocol information</b>		
Date (when submitting this form)	9 February 2018	
HREC REF Number	735/2017	
Protocol title	Barriers and facilitators of retention to a psychosocial intervention among adolescents with common mental disorders in Harare: A Qualitative Study.	
Protocol number (if applicable)	IRB00001938	
Principal Investigator	Ms. Emily Baron	
Department / Office Internal Mail Address	Psychiatry and Mental Health, Centre for Public Mental Health, Office 32, Building B, 46 Sawkins Road, Rondebosch 7700, South Africa	
1.1 Is this a major or a minor amendment? (see FHS006hlp) Major (tick box) Minor (tick box)	<input type="checkbox"/> Major	<input checked="" type="checkbox"/> Minor
1.2 Does this protocol receive US Federal funding?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
1.3 If the amendment is a major amendment and receives US Federal Funding, does the amendment require full committee approval?  Note: Any protocol amendments for Full Committee review MUST be submitted on the monthly HREC submission dates.	<input type="checkbox"/> Yes	N/A

## Appendix J: MRCZ Amendment

Telephone: 791792/791193/792747  
Telefax: (263) - 4 - 253979  
E-mail: [mrcz@mrcz.org.zw](mailto:mrcz@mrcz.org.zw)  
Website: [www.mrcz.org.zw](http://www.mrcz.org.zw)



Medical Research Council of Zimbabwe  
Josiah Tongogara / Mazoe Street  
P. O. Box CY 573  
Causeway  
Harare

MRCZ/B/1404

19 February 2018

Rhulani T. Beji - Chauke  
University of Cape Town

**RE: - Amendment Application: - Barriers and facilitators of retention to a psychosocial intervention among adolescents with common mental disorders in Harare: A Qualitative Study**

We refer to your submission received on the 15<sup>th</sup> of February, 2018 on the above mentioned subject.

Please be advised that the MRCZ has **reviewed** and **approved** your requests to:-

1. Add study sites from 5 Harare City Clinics to all of them.
2. Change the inclusion criteria time zone from June 2016 – June 2017 to June 2016 – December 2017.
3. Create a new adult consent form to cater for participants who were aged 17 at the time of accessing the service but are now 18 years of age or more.
4. Add invitation of study participants by Lay Health Workers.
5. Review the interview duration to 30 – 60 minutes from 60 minutes.

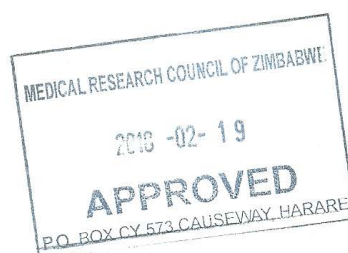
Correspondingly, the following has been approved:

1. Protocol Version 6.6 dated 06 February, 2018.
2. Adult Consent Form (English and Shona).

Yours Faithfully

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MRCZ SECRETARIAT  
FOR CHAIRPERSON  
MEDICAL RESEARCH COUNCIL OF ZIMBABWE



PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

## Appendix K: COREQ Checklist

### Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:

Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

**YOU MUST PROVIDE A RESPONSE FOR ALL ITEMS. ENTER N/A IF NOT APPLICABLE**

No. Item	Guide questions/description	Response
<b>Domain 1: Research team and reflexivity</b>		
<i>Personal Characteristics</i>		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	CRM & ECM
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	Honours Degree in Psychology
3. Occupation	What was their occupation at the time of the study?	CRM was a qualitative interviewer  ECM was a Clinical supervisor
4. Gender	Was the researcher male or female?	Both were female
5. Experience and training	What experience or training did the researcher have?	Two years experience conducting qualitative interviews.

		Both CRM and ECM conducted research qualitative research modules as part of their degree programs.
<i>Relationship with participants</i>		
6. Relationship established	Was a relationship established prior to study commencement?	The participants were not acquainted to the researchers prior to the study commencements.
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	The participants knew that the study sought to identify barriers and facilitators to retention.
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	None
<b>Domain 2: study design</b>		
<i>Theoretical framework</i>		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Thematic analysis
<i>Participant selection</i>		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Stratified sampling
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Telephone

12. Sample size	How many participants were in the study?	12
13. Non-participation	How many people refused to participate or dropped out? Reasons?	6 refused to participate: 3 – opted for telephone interviews 2 – work commitments 1 – gave no reason/s
<i>Setting</i>		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	Clinics, park, community hall.
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	No
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	See Table 1
<i>Data collection</i>		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Questions, prompts and guides were provided. The interview guide was pilot tested.
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	No repeat interviews were carried out.
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Audio recording
20. Field notes	Were field notes made during and/or after the interview or focus group?	Field notes were made both during and after interviews.
21. Duration	What was the duration of the interviews or focus group?	Interviews lasted in 15-30 minutes each.
22. Data saturation	Was data saturation discussed?	Yes in the methods section.
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	No.
<b>Domain 3: analysis and</b>		

<b>findings</b>		
<i>Data analysis</i>		
24. Number of data coders	How many data coders coded the data?	One
25. Description of the coding tree	Did authors provide a description of the coding tree?	No
26. Derivation of themes	Were themes identified in advance or derived from the data?	Themes were identified from a framework
27. Software	What software, if applicable, was used to manage the data?	NVivo 12
28. Participant checking	Did participants provide feedback on the findings?	This was not conducted
<i>Reporting</i>		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Supporting quotations were presented
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes
31. Clarity of major themes	Were major themes clearly presented in the findings?	A clear presentation of major themes is outlined
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Yes. These are presented.